Allied Health Professions into Action

Using Allied Health Professionals to transform health, care and wellbeing.

2016/17 - 2020/21

#AHPsintoAction

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AHPs into Action
Using Allied Health Professionals to transform health, care and wellbeing.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

Foreword

It is two years since I took on the role of Chief Allied Health Professions Officer for England. I am proud to represent allied health professionals (AHPs) employed in the NHS, together with those working in social care, higher education, independent sector, housing and voluntary organisations where these roles are funded by the taxpayer.

I have travelled widely across England in this time and been privileged to meet many AHPs, the citizens whose lives they touch and their employers. A direct result of these visits, and my meetings with local system leaders, suggested that it would be most appropriate - and presently we understand unique in such a national policy context - to develop a framework for AHPs in England via crowdsourcing. Crowdsourcing is a process of empowering people to solve challenges and generate collective insight via use of an online digital platform. By engaging with and supporting this platform, AHPs have demonstrated their commitment to innovate and actively seek solutions.

The resulting 'AHPs into Action' depicts the wide and diverse nature of what AHPs collectively offer to the system and the citizens they serve.

Not every aspect of the whole 'AHPs into Action' will be entirely relevant for each of the individual allied health professions, given the diversity of their work. But this is not what we collectively set out to achieve.

AHPs are the third largest workforce in health and care in England and 'AHPs into Action' sets out their collective commitments and priorities to deliver significant impacts for patients, their carers and communities. Whilst the work has been undertaken as part of my remit as professional lead for the 12 AHP professional groups, it has been recognised throughout the development of 'AHPs into Action', that there are other professional groups who regard themselves as allied to health.

'AHPs into Action' is inclusive and reflects how we work together in multi-professional teams, such that those who align themselves to it and support it are encouraged to use its findings to continually improve and redesign services. There were over 16,000 contributions to the on line digital platform and not one of them said leave things the way they are.

As CAHPO for England and in partnership with senior professional leaders in England, I am delighted to lead the launch of 'AHPs into Action'. It is a blueprint which can be used to support local and regional decision making about AHPs, the services they offer, how they can be most efficiently and effectively utilised and to assess areas requiring action to enable the change required to deliver future care across the system. 'AHPs into Action' will be of interest to those taking forward Sustainability and Transformation Plans (STPs), to commissioners of services, to AHP services, educators and to individual AHPs.

Suzanne Rastrick
Chief Allied Health Professions Officer, NHS England

Executive summary

'AHPs into Action' is a product for leaders and decision makers, to inform and inspire the system about how AHPs can be best utilised to support future health, care and wellbeing service delivery. It offers examples of innovative AHP practice and a framework to develop a plan of delivery.

'AHPs into Action' defines how AHPs can support STPs implement the triple aim set out in the Five Year Forward View; driving improvements in health and wellbeing, restoring and maintaining financial balance and delivering core quality standards.

'AHPs into Action' has been co-produced using triangulation of data and evidence:

• A review of national policy documents and publications.

• Engagement and involvement from senior leaders across the system.

• Over 16,000 contributions were submitted from patients, carers, the public, and health and care staff including AHPs, through a process of crowdsourcing via an online platform.

In summary, 'AHPs into Action' describes the:

• impact of the effective and efficient use of AHPs for people and populations

• commitment to the way services are delivered

• priorities to meet the challenges of changing care needs.

Part 1 describes AHPs transformative potential within the health, care and wider system. It gives case examples of where AHPs have achieved significant impact in addressing the challenges posed in addressing the triple aim set out in the Five Year Forward View[1] and described in more detail in Delivering the Forward View: NHS planning guidance[2].

Part 2 provides a blueprint for action, with 16 challenge questions posed in a framework, based on the commitments and priorities identified by AHPs, to guide thinking when developing a plan of delivery. This framework will help to identify best practice currently being delivered and any gaps requiring action.

AHPs into Action offers the system the authority to act. To support AHPs transform care, improve services and have a continued focus on efficiency, leaders across the system will need to play a part in it's delivery:

• The CAHPO as the most senior officer in England for AHPs.

• System leaders, whether they are employed in provider, commissioner, HEI or other organisations, responsible for decision making.

• AHPs who deliver services to citizens, in roles funded by the taxpayer.

The CAHPO, system leaders and AHPs responsibilities are described in more detail in the final section 'AHPs into Action'.

'AHPs into Action' cannot address all that this workforce has to offer. However, what is does represent is the start of a journey to highlight the transformative potential of AHPs within the health, social and wider care system.

Diagram 1
AHPs into Action

AHPs into Action

#AHPsintoAction

Our collective commitments and priorities will deliver significant impacts for patients, their carers, communities and populations.

Impact

The Impact
of the effective and efficient use of AHPs for people and populations

1. Improve the health and well-being of individuals and populations.
2. Support and provide solutions to general practice and urgent and emergency services to address demand.
3. Support integration, addressing historical service boundaries to reduce duplication and fragmentation.
4. Deliver evidence based/informed practice to address unexplained variances in service quality and efficiency.

How?

Commitment

Plus

Priorities

Our Commitments
to the way services are delivered

1. Commitment to the individual.
2. Commitment to keep care closer to home.
3. Commitment to the health and well being of populations.
4. Commitment to care for those who care.

Our Priorities
to meet the challenges of changing care needs

1. AHPs can lead change.
2. AHPs skills can be further developed.
3. AHPs evaluate, improve and evidence the impact of their contribution.
4. AHPs can utilise information & technology.

A blueprint to support system leaders make decisions about AHPs, the services they offer, and how they can be most efficiently and effectively utilised.

16,128 contributions were submitted from services users, carers, citizens and health and care staff including AHPs, through a process of crowdsourcing. 'AHPs into Action' represents their collective voice.

Part 1

AHPs key to transforming health, care and wellbeing in England.

Part 1 -
AHPs key to transforming health, care and wellbeing in England.

'AHPs into Action' identifies the AHPs transformative potential within health, care and the wider system. Never before has there been professional consensus gained on how care should be delivered by such a diverse group of professionals. This 'AHPs into Action' document, which gives the authority to act, represents the voice of AHPs and the wider system, including the public. It is a collective agreement which describes and demonstrates that AHPs are ready, prepared and have the skills to deliver what is required in an emerging and flexible system.

The breadth of AHPs skills and reach across people's lives and organisations make them ideally placed to lead and support transformative change. It is therefore vital that this workforce is utilised to best effect to deliver the triple aim and address the three challenges facing the system;

"Good organisations cannot implement the Five Year Forward View[1] and deliver the required productivity savings and care redesign in silos. Only through a system-wide set of changes will the NHS be sure of being able to deliver the right care, in the right place, with optimal value. The solutions will not come solely from within the NHS, but from patients and communities, and wider partnerships including local government, and the third sector; and effective public engagement will be essential to their success".

NHS England, NHS Operational Planning and Contracting Guidance, 2016 [25].

Health and wellbeing

Care and quality

Finance and efficiency

1. How will you close the health and wellbeing gap?

2. How will you drive transformation to close the care and quality gap?

3. How will you close the finance and efficiency gap?

'AHPs into Action' is a product for leaders and decision makers. It offers them current examples of innovative AHP practice, service redesign and delivery and a vision for this workforce for the future. The purpose of the document is to inform and inspire the contribution that AHPs can make directly in supporting the delivery of the triple aim through the vehicle of the STPs.

"I honestly believe that if all AHPs in England were used effectively, it would signal the total transformation of health and social care which we desperately need. We save lives, we rebuild lives and we do it all at a fraction of the cost of other colleagues. We understand the medical but crucially, we understand the social determinants of health -education, poverty, housing, stigma". Anon: April-May 2016. Direct quote; contributed to phase one of AHP online workshop.

A suggestion from the crowd was that AHPs should adopt the Aboriginal definition of health, "…not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. It is a whole of life view and includes the cyclical concept of life-death-life" [3].

Collectively AHPs have the skills, knowledge and expertise to lead change in the health, social and wider care system (see appendix 1 for more detailed descriptions of the individual professions). If the skills of AHPs are used effectively across the system, local communities and individuals will experience the following benefits:

- My community and I will be happier, healthier and have greater control of our own health, care and wellbeing.
- I will be able to see the right person, the first time, when and where I need to.
- Everyone involved in my care, including myself, family and carers, will work together to address my needs in the best way possible.
- No matter where I receive care I will be offered the same level of service.

The impact for individuals and populations

If AHPs are used effectively there will be substantial benefits for individuals, communities and for the taxpayer, as AHPs are ideally suited to address many of the key challenges faced by England's health, social and wider care systems.

System leaders need to harness AHPs to deliver quality and cost effective outcomes for individuals and populations. In particular this will deliver the four impacts highlighted in the table below. These impacts align with the triple aim and the national challenges facing STPs.

AHPs key to transforming health, care and wellbeing in England.			
How will you close the health and wellbeing gap?	How will you drive transformation to close the care and quality gap?		How will you close the finance and efficiency gap?
IMPACT 1	IMPACT 2	IMPACT 3	IMPACT 4
AHPs will improve the health and wellbeing of people and populations.	AHPs will support and provide solutions to general practice and urgent and emergency services to address demand.	AHPs will support integration, addressing historical service boundaries to reduce duplication and fragmentation.	AHPs will deliver evidence based/ informed practice to address unexplained variances in service quality and efficiency.

Impact 1 -
AHPs will improve the health and wellbeing of individuals and populations.

'My community and I will be happier, healthier and have greater control of our health, care and wellbeing'.

Improving the health and wellbeing of individuals and populations depends on AHPs and people who use services, their families and carers working together and employing strategies to manage demand, prevent dependency and support individuals and their families to live healthy fulfilling lives at home, or as close to home as possible, for as long as possible. Enabling approaches, including reablement, rehabilitation and supported self-management, play a central role in underpinning this[4].

Many AHPs have expertise particularly relevant to working with individuals enabling them to take control of their own health and wellbeing, for example through exercise, diet or supporting mental wellbeing. AHPs working within the community or in home environments can offer effective prevention strategies which support self care and management; many are involved in health screening, health promotion, public health, social inclusion and participation initiatives and in advising individuals, family members and carers who access their services. AHPs have also led national initiatives. The British Dietetic Association launched 'Work Ready' in 2015 which is a dietitian-led initiative designed to help the workforce stay healthy and well at work.

AHPs have promoted national initiatives such as 'All Our Health'; a call to action to healthcare professionals working with patients and the population to prevent illness, protect health and promote wellbeing[5].

In April 2014, AHPs agreed a collective ambition to be recognised as an integral part of the public health workforce. In 2015, Public Health England and the Allied Health Professions Federation (AHPF) produced the first strategy to develop the capacity, impact and profile of AHPs in public health[6]. It recognised the development of the AHP contribution and profile to the prevention agenda and the growing examples of AHP-led public health initiatives across the life course. It provides a clear definition of public health for AHPs, the vision, strategic approach and goals.

AHPs are also recognised as being among the principal groups of professionals who can make accurate functional capacity assessments, intervene through vocational rehabilitation activities as part of treatment and recovery and advise colleagues, the individual and the employer on reasonable adjustments for rapid and successful return to work. All of these factors mean that the role of the AHP professions has never been more vital[7].

> **"As a patient I am pleased to see the recognition of individual and population/community wellbeing as this is interlinked. There is huge potential for AHPs to become strong bridge builders between healthcare and patients/citizens/communities helping to renegotiate the relationship between citizens and health/ healthcare, e.g. implementing shared decision and co-production approaches, promoting selfcare and education, being the pioneers of using digital as an enabler etc".**
>
> Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop

Challenges STPs must address Questions taken directly from Annex 1, NHS England, Delivering the Five Year Forward View: NHS planning guidance 2016/17 - 2020/21.	AHPs innovative solutions to improving the health and wellbeing of individuals and populations
How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities?	Stoke Speaks Out. Population based research influencing children's eye care. Embedding a health promotion strategy. Eat, Drink, Move.
How are the NHS and other employers in your area going to improve the health of their own workforce?	Influencing physical activity through social media. Fitness For Work Service. Occupational Health Service.
How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme?	Move Away from Prediabetes (MAP). Diabetic Foot Screening app. Fixing foot care in Sheffield.
What action will you take to address obesity, including childhood obesity?	Waistlines. Family Food First programme. Multidisciplinary weight management service. Physical activity for weight management.
How will you achieve step-change in patient activation and selfcare?	Health coaching. Good Lives.

Further details of each of the innovative solutions can be found in Appendix 4. Alternatively please click on the title of each and you will be directed to that case study.

Further examples where there is good evidence of impact on public health by AHPs can be found in a report commissioned by Public Health England (PHE), carried out by Sheffield Hallam University[8].

"AHPs have a huge impact in ensuring the health and wellbeing at individual and population level, whilst it may seem evident to AHPs it is less evident to the system especially in terms of population level impact of AHP interventions, we are often better at describing individual patient level improvements but often find it hard to concisely articulate population level impact which is what is needed to establish "value". We need to become better at this narrative which should inform the focus on sustainability and transformation."

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop

Impact 2 -
AHPs will support and provide solutions to general practice and urgent and emergency services to address demand.

'I will be able to see the right person, the first time, when and where I need to'.

AHPs' expertise in rehabilitation and enablement is vital to the paradigmatic shift away from over-reliance on hospitals and professional interventions from across health and social care. Reducing inappropriate admissions (through AHP services being based in accident and emergency departments, for instance) and unnecessary care costs (through integration of rehabilitation and homecare services) are necessary to ensure affordable and sustainable services in the future. AHP interventions can significantly reduce unnecessary admissions to hospital and diminish dependency on care services, resulting in significant savings.

As first-point-of-contact practitioners, AHPs also make a vital contribution to faster diagnostics and earlier interventions in primary care. A key opportunity to improve access to care, reduce waiting times and reduce costs is to enable direct access to AHPs for some conditions or purposes. Self-referral may be directly to specific AHPs, or to teams in which AHPs are part of a multidisciplinary team involving a range of professions. There is unacceptably wide variation across England in the availability of self-referral to some AHP services.

The GP Forward View[9] includes commitments to the greater use of non-medical clinicians in primary care. There are well developed models for paramedics, physiotherapists, occupational therapists and other AHPs to work alongside family doctors and practice nurses. Improved direct access to AHPs will avoid placing demands solely on any one profession or part of the system, improve access for patients and increase capacity within the system.

Services need to be designed in ways which harness the clinical expertise of AHPs to improve patient/service user outcomes and to maximise cost effectiveness. More importantly, AHPs working in primary care will improve responsiveness to people's preferences, lifestyles and goals. Self-referral, primary care based AHPs and AHP supported selfcare all have the potential to transform services whilst saving the system significant costs and can offer alternatives to urgent and emergency services.

Challenges STPs must address Questions taken directly from Annex 1, NHS England, Delivering the Five Year Forward View: NHS planning guidance 2016/17 - 2020/21.	**AHPs innovative solutions to support general practice and urgent and emergency services to address demand**
What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure?	MSK first contact practitioner. Management of irritable bowel syndrome. Direct Access Physiotherapy Service. First point of contact care for people with MSK related conditions. Physiotherapy - changing the face of primary care.
What are your plans to adopt new models of out of hospital care, e.g. Primary and Acute Care Systems (PACS)?	Community paramedics keeping people out of hospital. Virtual Orthopaedic Fracture Clinic. Dysphagia management improves quality of life and reduces medical complications and death.

Further details of each of the innovative solutions can be found in . Alternatively please click on the title of each and you will be directed to that case study.

"It is essential that AHPs have a greater presence in primary care, that where appropriate they can manage a significant portion of the GP caseload e.g. MSK problems. Funding needs to be available to support the development of new skills in staff that enable a more efficient and effective seamless provision e.g. prescribing, sonography. Also need to acknowledge that enhancement of GP surgeries would reduce dependence upon A&E departments. Need to consider the paramedic contribution in this proposition. Need to ensure that advanced practice roles and extended scope roles are effectively developed and utilised".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop

"It is not my experience working with adults with learning disabilities that we rely on GPs or acute services; rather they rely on AHPs for specialist expertise. Referrals are made straight to AHPs".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop

I would think it is more around collaboratively utilising our skills and competences symbiotically for patient benefit, adding value by freeing up GP time to care, whilst showcasing our unique talents for managing list based patients at reduced cost and better outcome".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop

"I think we should be talking about a new model of care which integrates the role of AHPs and patients, focuses more on prevention and selfcare. If this was the case then there would be less use of GPs and acute care but the primary purpose would be to improve health and wellbeing and better use of the resources AHPs and patients bring".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop

"We should be looking to develop more integrated and supportive systems that wrap around current primary care provision. Having spent just over two years setting up a primary care mental health service and being part of a Joint Care Team pilot in Ealing I saw that there is a lot of potential for delivering care differently and more effectively if agencies are incentivised to work together at the front end of care".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop

Impact 3 -
AHPs will support integration, addressing historical service boundaries to reduce duplication and fragmentation.

'Everyone involved in my care, including myself, family and carers, will work together to address my needs in the best way possible'.

AHPs are expert in rehabilitation at the point of registration and bring a different perspective to the planning and delivery of services. They are uniquely placed to exploit their expertise in enabling approaches through providing rehabilitation/reablement approaches and leadership across health, care and well being services as well as driving integrated approaches at the point of care.

AHPs can lead care coordination, particularly for patients with multiple co-morbidities. AHPs are often the crucial bridge for those navigating the system. Their models of service delivery often move away from traditional service divides e.g. community/acute, community/primary, mental/ physical health or health/social care.

AHPs are often key agents in developing parity between physical and mental health. The clinical model used by many AHP professionals emphasises the links between physical and mental wellbeing. Some AHPs, such as occupational therapists who are dual trained, also specialise in mental health within their professional practice.

However, it can be difficult for AHPs to deliver integrated care due to the current architecture of locally commissioned services. This should be addressed through the STP process. Well managed multidisciplinary services, integrated across acute and community services, with access to senior AHPs in each profession for specialist clinical advice, can help to ensure that care can be accessed in a timely and seamless way.

"As AHPs we need to work together towards services that we aspire to provide rather than being constrained by organisational boundaries. We all have common goals in improving care and this needs to work in both acute and community without being limited by the structure that services are provided in".

Anon: July 2016. Direct quote; contributed to phase two of AHP online workshop.

"I work in a service which provides speech and language therapy (SLT) across acute and community services. This results in seamless care across the pathway. In other professions this is not the case and there is evidence of both acute professions and their community counterparts then both trying to develop services which is confusing for patients. An AHP journey from acute to community and vice versa ensures patients have a holistic experience".

Anon: July 2016. Direct quote; contributed to phase two of AHP online workshop.

Challenges STPs must address Questions taken directly from Annex 1, NHS England, Delivering the Five Year Forward View: NHS planning guidance 2016/17 - 2020/21.	AHPs innovative solutions to support integration
What are your plans to adopt new models of out of hospital care, e.g. Multi-specialty Community Providers (MCPs)?	Integration of adult community therapy. Integrated Care Services - iCares.
What is your plan for transforming urgent and emergency care in your area?	Early Intervention Team. Barnet Rapid Response Team. AHPs responding to emergency calls that are not life-threatening. Occupational therapy led service in the emergency department. Pennine Lancashire Falls Response Service (FRS).
What's your agreed recovery plan to achieve and maintain A&E access standards?	Radiographer reporting. Frailty Assessment Base (FAB). Physiotherapists in accident and emergency.
How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?	Breast cancer rehabilitation service. Advanced Practice in Oncology. Therapeutic radiographers in site specialist roles. Consultant radiographer role. Keeping people with altered airways safe in their homes. Recognising and addressing the social impact of eating and drinking difficulties.
How will you improve mental health services?	Partnership working to deliver public health and fire safety checks. Walk Faster, Walk Further.
What steps will your local area take to improve dementia services?	Challenging traditional approaches to care practice for people with dementia. Greenview Intermediate Care Unit.
How will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital?	Transforming eye care to children with Special Educational Needs (SEN). Sport for Confidence. Art therapy in cultural spaces.

Further details of each of the innovative solutions can be found in Appendix 4. Alternatively please click on the title of each and you will be directed to that case study.

Impact 4 -
AHPs will deliver evidence based/informed practice to address unexplained variances in service quality and efficiency.

'No matter where I receive care I will be offered the same level of service'.

AHPs will continue to support this pursuit ensuring comparable services deliver comparable quality and cost effectiveness;

- AHPs deliver evidence based practice and will always use evidence based / informed practice to support the achievement of citizen outcomes.
- AHPs will consistently measure their impact to optimise productivity and efficiency.

This is critical to greater coherence and parity of service delivery, whilst maintaining an individualised approach to patients and service users.

The importance of citizen outcomes and the pursuit of them in healthcare and the NHS have been widely recognised for many years - from preventing people from dying prematurely to helping people to enhance their quality of life. To build on this NHS England and Public Health England are taking forward the RightCare approach through new programmes to ensure that it becomes embedded in the new commissioning and public health agendas for the NHS. The primary objectives are to maximise the value that the patient derives from their own care and treatment, and the value the whole population derives from the investment in their healthcare.

To support NHS providers to deliver the right staff and skills, in the right time and place, the National Quality Board (NQB) published an updated safe staffing resource for NHS provider boards to assure the delivery of compassionate, effective, safe, sustainable high quality patient care. To help to achieve the Five Year Forward View's ambitions, the principles contained in this resource apply to the broader multi-professional workforce in a range of care settings, and do so in a way that optimises productivity and efficiency while maintaining the focus on improving quality[10].

The Royal College of Speech and Language Therapists (RCSLT) is piloting an online proof of concept tool to support speech and language therapists to collect and collate Therapy Outcome Measures (TOMs)[11]. The tool generates data reports that can be viewed by therapists to track change for individual service users as well as aggregated reports which enable analysis of outcomes at a service level.

Challenges STPs must address Questions taken directly from Annex 1, NHS England, Delivering the Five Year Forward View: NHS planning guidance 2016/17 - 2020/21.	AHPs innovative solutions to deliver service quality and efficiency
How will you reduce costs and how will you get the most out of your existing workforce?	Ward-based therapists as an integral part to the nursing team. Integrated therapy roles. Redesigning multidisciplinary ward teams. Advanced Practice reporting radiographers. Utilising radiography skill mix to increase imaging capacity and capability.
How are you improving workforce productivity?	Improving efficiency and patient experience through effective job planning. Safe staffing for occupational therapy.

Further details of each of the innovative solutions can be found in Appendix 4. Alternatively please click on the title of each and you will be directed to that case study.

"I would agree with the need to reduce unwarranted variation in service outcomes and patient experience totally. Unwarranted variation in productivity, quality and effectiveness needs to be addressed in AHP services as a matter of urgency. Why should quality and outcomes be better in one area compared to another when adjusting for things like complexity/workforce and other determinants, the variation in outcomes of our interventions and myriad baskets of outcome measures make the narrative that we add value much, much more difficult.

Anon: July 2016. Direct quote; contributed to phase two of AHP online workshop.

Part 2

Enabling AHPs to transform health, care and wellbeing.

Part 2 -
Enabling AHPs to transform health, care and wellbeing.

This section, describes a framework for system leaders to enable AHPs to transform care. It has been developed based on:

- **Four commitments (See Appendix 3) to the way services are delivered by AHPs.**
    1. Commitment to the individual
    2. Commitment to keep care closer to home
    3. Commitment to the health and wellbeing of populations.
    4. Commitment to care for those who care.

- **Four priorities (See Appendix 4) for AHPs to meet the challenges of changing care needs.**
    1. AHPs can lead change.
    2. AHPs' skills can be further developed.
    3. AHPs evaluate, improve and evidence the impact of their contribution.
    4. AHPs can utilise information and technology.

The framework poses questions to help system leaders and other local decision makers address how they will utilise the potential of AHPs. It should be used to support the development of a local plan to support the delivery of the impacts described in part 1.

A framework to support local decision makers to address how they utilise the potential of AHPs.

Focusing on the priority actions and guided by the commitments made, the framework below provides a structure to develop a local plan of delivery. Boards, STPs, Higher Education Institutions (HEIs) and academics should review their strategies against the framework. The challenge questions in the sixteen boxes below are offered to guide thinking when developing that local plan. This tool will help to identify best practice and any gaps requiring action to support delivery of 'AHPs into Action'.

	...guided by the commitments made.			
	Commitment to the individual	**Commitment to keep care closer to home**	**Commitment to the health and wellbeing of populations**	**Commitment to care for those who care**
AHPs can lead change	How can we make better use of AHPs as autonomous clinicians and as part of multidisciplinary teams (MDT) to improve access to appropriate care?	Are we using AHPs to provide services in different settings closer to home? Such as in GP surgeries, care homes, community outreach services and other non-acute settings? Are the recovery, reablement and rehabilitation skills of AHPs being used to address quality of life and employability?	Are we using the unique skills of all appropriate AHP professions in an integrated way to respond to local public health challenges and to prevent ill-health? Are AHP services supported to redesign their offer to focus on prevention?	Are we using the specialist skills of AHPs to ensure the health and wellbeing of colleagues whilst also ensuring an environment is provided that makes people feel healthy, happy and well?
AHPs' skills can be further developed	How are AHPs supported in enhancing their unique skills within integrated teams, share skills and to acquire wider skills to support other parts of the system, or to reduce duplication?	How are AHPs involved in developing new care models? Are plans which need staff to work differently, in different roles, in different settings and at different times of the day, developed with AHPs?	Is the AHP contribution to local public health and prevention intervention explicit and encouraged? This may involve identifying what AHPs do well now whilst also developing the workforce where there is potential to enhance the AHP contribution.	Are you delivering and/or offering inter-professional education and practice (both at undergraduate and postgraduate)? Do you have a commitment to the development of both clinical and non-clinical skills amongst the AHP workforce?

Priority actions...

...guided by the commitments made.				
	Commitment to the individual	**Commitment to keep care closer to home**	**Commitment to the health and wellbeing of populations**	**Commitment to care for those who care**
AHPs evaluate, improve and evidence the impact of their contribution	Do you ensure information/data is collected which demonstrates the quality and cost effectiveness of the care delivered by AHPs? This should include inputs (workforce measurement), outputs (workload measurement) and outcome measurement.	Is there a commitment to work towards a uniform data set which collectively and consistently measures the value of AHP care at an individual and population level?	How are AHPs supported to contribute to, share and respond to local, regional and national evidence regarding public health and prevention?	Are you collecting evidence about the care AHPs provide to their colleagues and to carers?
AHPs can utilise information and technology	How are you enabling AHPs to use information and technology to reduce unexplained variance across services?	Are AHPs being encouraged to develop and utilise information and technology to ensure people can selfcare and, when required, access and receive care close to home?	Is population level data shared with AHPs to enable them to consider how to address needs and how the application and/or use of technology could enhance the health and wellbeing of the local communities?	Do AHPs have access to technology to enable the sharing best practice across professions?

Priority actions...

AHPs into Action

'AHPs into Action' offers the system the authority to act. To support AHPs transform care, improve services and have a continued focus on efficiency, leaders across the system will need to play a part in it's delivery:

- The CAHPO as the most senior officer in England for AHPs.
- System leaders, whether they are employed in provider, commissioner, HEI or other organisations, responsible for decision making.
- AHPs who deliver services to citizens, in roles funded by the taxpayer.

CAHPO responsibilities

The CAHPO as sponsor of 'AHPs into Action' will provide strategic leadership to oversee and support the implementation of it. The vehicle to deliver this will be the establishment of a national programme board.

1. **The CAHPO will continue to work across the system to:**

   a. hold the system to account for the inclusion of the AHP voice at all levels of debate to ensure that policy and developments are sighted on the AHP contribution and how to maximise it in all aspects of service delivery.

   b. champion the AHP skills to contribute to the prevention, recovery, habilitation, reablement and rehabilitation, self-management and care, and return to work agendas. Such that they are clearly understood and fully utilised in practice to support the triple aim.

   c. ensure that local workforce action boards and therefore STPs are sighted on their AHP contribution opportunities including workforce supply and demand to ensure the availability of student placements in all settings to support the development of future workforce.

   d. actively promote the spread of new ways of working, building on the evidence, which liberate the full clinical and leadership contribution of the AHP workforce.

   e. ensure opportunities for AHPs to optimise their leadership potential to innovate and improve services.

2. **The CAHPO will continue to support NHS Improvement (NHSI) with the following national programmes.**

   a. NHS safe staffing improvement resources. The aim of which is to support and enable providers with making safe and sustainable staffing decisions in specific care settings. National work streams have been established to develop safe staffing improvement resources for the following care settings: mental health, learning disability, community, maternity, acute inpatients, children's services, urgent and emergency care.

   b. The NHSI AHP productivity programme to identify possible metrics by quantifying both the resources available (workforce) and activity (workload) that can be easily and widely applied. These include:

      i. The introduction of annual job planning as a means of recording and agreeing sessional contributions and planning the optimal use of AHP professional time.

      ii. An evaluation of 'Therapy Hours per Day' as a viable means of reporting clinical time to the system.

iii. Development of a classification system for AHP activity as a means of defining outputs and productivity.

iv. Developing an AHP dashboard for the Model Hospital Portal that will include metrics relevant to both clinical quality (outcomes) and productivity (workforce and workload).

3. **The CAHPO will work with HEE to:**

   a. Ensure that the significant opportunities AHPs have to offer to successful workforce transformation in practice and the ability to better support people and manage demand are understood and enabled.

   b. Deliver workforce planning which ensures high quality undergraduate and post graduate education to ensure adequate focus on the current skills of the workforce and any further ongoing requirements necessary for future care.

   c. Ensure the optimisation of the opportunity advanced practice offers to workforce transformation.

   d. Ensuring ongoing and increasing AHP engagement with clinical academic careers.

4. **The CAHPO will lead the development of an AHP informatics strategy with support from the National Allied Health Professions Informatics Strategic Taskforce (NAHPIST) and NHS Digital.**

System leaders' responsibilities

At a local and regional level 'AHPs into Action' is a tool to focus system leader attention on the areas where they should be considering the transformative role of AHPs and the support needed to achieve change. The framework in part two is provided to help system leaders and other local decision makers address how they will utilise the potential of AHPs. System leaders, including organisational boards in collaboration with their Local Workforce Action Board should review organisation strategies against the framework in part 2. And also:

1. Ensure explicit consideration of AHPs contribution and ambition in STPs. In particular their contribution to the prevention, recovery, habilitation, reablement and rehabilitation, self-management and care, and return to work agendas, such that they are fully utilised in practice to support the triple aim. Ensuring AHP leads have a clear voice and are represented at key clinical forums.

2. Support AHP services to evidence the quality and cost effectiveness of the care delivered by AHPs, to support continuing improvement and innovation in service delivery.

3. Have employer support for continued professional development and engagement in research activities for AHPs. And, engage AHPs in the workforce planning process.

4. Ensure AHPs have access to the tools and support required to continue to develop their use of informatics and technology to continue to deliver quality and cost effective care.

AHPs responsibilities

'AHPs into Action' identifies the AHPs transformative potential within health, care and the wider system. AHPs should support the review of organisational strategies against the framework in part 2 (LINK HERE) and actively support the system to deliver what is required to transform care.

1. AHPs should maximise the opportunity the 'AHPs into Action' offers to influence policy and development to ensure the system leaders are sighted on the AHP contribution and how to maximise it in all aspects of service delivery. AHPs should ensure they have a clear voice and are represented at key clinical forums.

2. AHPs will ensure their practice meets the Health and Care Professions Council (HCPC) standards and utilises, when and where appropriate, skills to contribute to the prevention, recovery, habilitation, reablement and rehabilitation, self-management and care, and return to work agendas. AHPs should assess workforce 'state of readiness for future care' utilising the guidance in appendix 4, priority 2 (LINK HERE).

3. AHPs will continue to demonstrate both the quality and cost effectiveness of the services they provide individually and collectively, within and out with integrated teams.

4. AHPs will access the tools and support required to continue to develop their use of informatics and technology to continue to deliver quality and cost effective care.

By collectively engaging in the process of the development of 'AHPs into Action', AHPs have demonstrated the power of AHP networks across England and their commitment to innovate and dynamically seek solutions. The power of this network in the development of 'AHPs into Action' cannot be underestimated.

The 'AHPs into Action' document, and the AHP workforce, cannot offer all the solutions nor the answers to the challenges facing the system. What it does offer is a workforce that already has a multitude of skills and innovative solutions to deliver and build a social movement that is future focused. It is a workforce that is, and has been prepared to, lift a mirror to ask themselves, "what do we need to stop, start or do differently" to support health, care and wellbeing now and in the future. For some system leaders this will be the start of a new journey to discover the opportunities this workforce has to offer. For others it will provide a much needed tool which will support the recognition and utilisation of the transformative potential of AHPs.

"As a patient I can say that many of my peers often don't understand or know the difference between the many AHP professions but that makes little difference as these professions generally work really well together. AHPs share particular skills, experiences and values whilst having a (for want of a better description) specialism. I think that more should be made of the collective voice of AHPs…I thought that the health and social care act was going to revolutionise and empower AHPs given their rehabilitation focus and determination to enable mobility, independence, dexterity and importantly keep people out of hospitals but something seems to be holding back the full benefits or opportunities to patients. Is this systems, processes and bureaucracy and/ or something else".

Anon: July 2016. Direct quote; contributed to phase two of AHP online workshop.

"The missing link… As a non-AHP, I speak outside of professional context - but AHPs are everything that a rejigged, refocused, public healthcare sector should focus on. They are utterly unique in the cradle to grave offering, unique in their mobility, unique in their ability to prevent, diagnose and treat. They are unique in their dual roles in health and local government and they are unique in their ability to be judged on both clinical and 'emotional' outcomes, they are unique in their dual roles in physical and mental health - At the risk of stating the obvious, if anyone is to lead the new care models, then AHPs are ideally placed".

Anon: April-May 2016. Direct quote; contributed to phase one of AHP online workshop.

Diagram 2
Allied Health Professions into Action
Impact, commitment and priorities
#AHPsintoAction

Impact **of the effective and efficient use of AHPs for people and populations.**

1. Improve the health and well-being of individuals and populations.

2. Support and provide solutions to general practice and urgent and emergency services to address demand.

3. Support integration, addressing historical service boundaries to reduce duplication and fragmentation.

4. Deliver evidence based/informed practice to address unexplained variances in service quality and efficiency.

Commitment **to the way services are delivered.**

1. Commitment to the individual.

2. Commitment to keep care close to home.

3. Commitment to the health and well-being of populations.

4. Commitment to care for those who care.

Priorities **to meet the challenges of changing care needs.**

1. AHPs can lead change.

2. AHPs skills can be further developed.

3. AHPs evaluate, improve and evidence the impact of their contribution.

4. AHPs can utilise information & technology.

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Appendix 1

AHPs.

Appendix 1
AHPs

The Five Year Forward View[1] is not unique in its conclusion that integrated approaches to care will help solve many of our nation's challenges. Integration[12], new public health approaches[13] and the smarter use of community-based assets and technology[14] are not novel ideas for many of England's AHPs[4].

AHPs are a diverse group of practitioners[15] but all the professions are recognised for their autonomy and ability to apply innovative solutions to challenges in an entrepreneurial way[16]. In addition to their profession-specific skills, AHPs have the ability to take on new roles and to step outside of traditional boundaries. They are therefore well placed to offer innovative solutions to develop and deliver what is required to radically transform care.

AHPs deliver prevention, assessment, diagnosis, intervention including treatment, discharge, and rehabilitation in a range of settings across the NHS, local authorities, the military, education and, independent and voluntary sectors. The added value AHPs bring is being recognised more widely and they are also now utilised by other organisations, for example in the fire service and care homes[6].

Art Therapists

Art therapists use visual art to help people who have difficulty expressing themselves verbally or in understanding their own feelings. Art therapists usually have a primary degree in art or are able to demonstrate lifelong engagement in art-making, as understanding art-based processes is at the heart of their practice.

Art therapists are employed in many different settings in the statutory and independent sectors e.g. education, prisons, hospitals, social services, charities, etc. Some also work in private practice. Art therapy clients include people of all ages, from early childhood to later life. Art therapy can be practised with individual clients and in groups.

Art therapists work closely with other professionals, such as other AHPs, psychiatrists, psychologists, social workers and teachers, to assess the client and decide on the therapy. Art therapists also take on other roles in organisations, such as managers, supervisors, etc.

Importantly, art therapists work side-by-side with service users and are able to adapt their practice to changing contexts of service delivery. They also ensure a close link between research evidence and best practice.

Drama Therapists

Drama therapy is a creative arts therapy based on the intentional use of healing aspects of drama and theatre as the therapeutic process. Its theoretical foundation lies in drama, theatre, psychology, psychotherapy, anthropology, play, as well as interactive and creative processes. The client does not need to have any previous acting experience and sessions are not usually performance based.

The focus is the use of play, story, metaphor, creativity and movement with verbal/non-verbal interventions offering a safer distance to explore experiences, emotions or thoughts, often traumatic that cannot always be expressed or understood through words alone.

Drama Therapists work within multidisciplinary settings supporting assessment, treatment, rehabilitation and preventative support with children, adolescence, adults and older adults. Services include mother and babies units to palliative care including schools, hospitals (both physical and mental health care settings), prisons and forensic services, care homes, communities and private practise. The use of non-verbal techniques allows a wide range of clients to access therapy including refugees and those with learning disabilities, autism, dementia, etc.

Drama therapy can offer short term projects specifically targeting a particular need to medium to long term therapy spaces, working individually and in group settings.

Music Therapists

Music therapists are psychological therapists who are highly skilled musicians and trained in psychological interventions using music as their primary mode of communication. Using an arts-based psychological therapy is particularly helpful when emotions are too confusing to express verbally, when verbal communication is difficult or when words are not enough or too much to bear.

Working alongside other professionals within multidisciplinary and multiagency teams, music therapists work in a diverse range of settings such as health and social care, education, the charitable sector, criminal justice and forensic services, and across these in acute settings, rehabilitation centres, community spaces, specialist music therapy centres, and in people's homes.

Music therapy is an established psychological clinical intervention, which is delivered by registered music therapists to help people whose lives have been affected by life events, injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs. Music therapists can support people flexibly at acute and rehabilitative stages of need. They are also able to offer preventative interventions. Music therapy can be both a short and long term support.

Working either individually or within groups, music therapy can support positive changes in mood and emotional wellbeing, development in physical, sensory and cognitive skills, increases in self-confidence, self-esteem, insight and motivation, offers opportunities for social interaction, and enhances quality of life.

Podiatrists

Podiatrists help to keep the population mobile and active, and prevent foot conditions from deteriorating. Podiatrists enable better health for the population and support people to be pain free, active, and remain in work.

Podiatrists are core members of all foot related services irrespective of the condition. Podiatry is intrinsic to multiple care pathways and podiatrists liaise between community, residential, domiciliary, and acute and primary care settings.

Podiatrists are degree educated clinicians, who manage a wide range of conditions including complex foot ulcers in people with high-risk long term medical conditions such as diabetes and peripheral arterial disease. Podiatrists deal with the assessment, diagnosis and treatment of the lower limb. They are qualified to deal with soft tissue musculoskeletal (MSK) and systemic conditions which manifest in the lower limb and foot.

Podiatrists work with a wide range of people across the life span, from infants to palliative care, but play a particularly important role in helping older people to stay mobile, independent and prevent falls. They work with people suffering from a wide variety of conditions affecting the lower limb and foot including complex biomechanical and structural dysfunction; those with osteoarthritis or rheumatoid arthritis and those with dermatological disorders.

Specialist education and training may be undertaken in order to carry out surgical treatment of the foot and its associated structures; podiatric surgeons perform such procedures under local anaesthetic, thus making this a viable, cost-effective procedure. Podiatrists now have the ability to prescribe medicines, previously only available through a doctor. This is a more cost-effective and time saving method of prescribing.

Podiatrists work collaboratively with their patients, carers, GPs, consultants, other healthcare professionals and AHPs to enable lifestyle changes and support the best health outcomes possible.

Dietitians

Registered dietitians assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. They work within all areas of the NHS (primary, secondary and tertiary care) as well as within public health, local government, care settings, research, industry and private practice. Dietitians use the most up to date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. They work with a wide range of patients in every age group, helping to treat, manage and speed recovery from a complex and varied range of conditions from diabetes to allergies, cancer to mental health. 10.8 percent of the UKs disease burden is associated with unhealthy diet (ref: https://publichealthmatters.blog.gov.uk/2015/09/15/the-burden-of-disease-and-what-it-means-in-england/) making it the largest single preventable cause of ill health. Dietitians therefore have a critical role to play in reducing the burden on the NHS and improving the public's health.

Occupational Therapists

Occupational therapists work with people of all ages and backgrounds who are affected by accident, physical and mental illness, disability or ageing. They:

- provide help and training in daily activities, such as bathing, dressing, eating, gardening, working and learning

- offer advice on adapting your home or workplace to meet your needs

- assess and recommend equipment, such as mobility aids, wheelchairs and artificial limbs and, if needed, advise on special devices to help around the home, school or workplace

- help children with disabilities to build their confidence, enabling them to take part in school activities

- work with organisations to improve employees' performance

- provide cost benefits to service commissioners.

Occupational therapists work in health care, social services, schools, prisons, industry and employment services. In the main, their work relates to how you manage in your home, school, work or care environment.

Occupational Therapists can help people of all ages when the everyday activities, such as getting out of bed in the morning, getting washed, preparing meals, going to work or school, become difficult. Accident, illness, disability and ageing can turn everyday activities into challenges which

reduce independence and undermine our sense of identity. Occupational therapists recognise that being able to perform these daily activities is crucial to health and wellbeing.

Occupational therapists enable people to manage activities that are important to them independently. This helps develop confidence and reduces strain and demand on carers. It means costly care packages are avoided and that people can live their lives to the full.

Orthopists

Orthoptists are eye and vision specialists and experts in how the eyes move and work together. An orthoptist assesses, diagnoses, treats and monitors a variety of eye disorders.

Most orthoptists in the UK are employed by the NHS and work in hospitals community clinics, rehabilitation centres, special schools and child development centres as well as mainstream schools.

Orthoptists assess, diagnose and treat patients presenting with:

- double vision
- blurred vision
- amblyopia (sometimes known as a lazy eye)
- strabismus (misalignment of the eyes)
- refractive errors
- ptosis (drooping of the eye lid)
- nystagmus (uncontrolled constant eye movements)
- ocular head postures
- neurological conditions; stroke, traumatic brain injury, brain tumours, Multiple sclerosis & degenerative conditions e.g. Parkinson's disease, inflammatory & neuromuscular conditions.
- visual defects in association with learning disabilities
- visual processing disorders
- low vision and visual field loss.

Orthoptists core outcomes are:

- Preventing treatable visual loss with screening programmes and healthy lifestyle choices.
- Restoring vision and binocular vision - improving educational outcomes, quality of life, employment opportunities and independence.
- Improving rehabilitation goals by early identification of visual complications.

Prosthetists and Orthotists

Prosthetists and orthotists are autonomous registered practitioners who provide gait analysis and engineering solutions. Both prosthetists and orthotists practice in acute and community settings. They are extensively trained at undergraduate level in mechanics, bio-mechanics, material science, anatomy, physiology and pathophysiology. They are qualified to modify prosthetic and orthotic componentry, taking responsibility for the impact of any changes.

Prosthetists treat patients with limb loss resulting from congenital absence, complications of diabetes, reduced vascularity, infection and trauma. They design and provide prostheses; artificial limbs that replicate the structural or functional characteristics of the patient's absent limb.

Military personnel are forming an increasing part of their caseload. They often work closely with physiotherapists and occupational therapists as part of multidisciplinary amputee rehabilitation teams.

Orthotists treat patients with problems of the neuro, muscular and skeletal systems resulting from conditions such as: diabetes, arthritis, cerebral palsy, stroke, spina bifida, scoliosis, MSK, sports injuries and trauma. They design and provide orthoses; externally applied devices that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They often form part of multidisciplinary teams such as the diabetic foot team or neuro-rehabilitation team.

Paramedics

There are more than 22,000 registered paramedics in the UK. Most paramedics work in NHS ambulance services but increasing numbers work in private ambulance companies, NHS walk-in centres and minor injury units and in GP practices, with many others working in offshore and remote settings often as the only available healthcare professional.

The historic core will continue, in which paramedics crewed ambulances and responded to 999 calls and other urgent cases for conveyance to hospitals, but has also changed significantly. Ambulance paramedics along with their colleagues in the emergent settings noted above undertake more extensive assessment and diagnoses and treat or refer many patients without conveyance to hospitals. The emphasis on safe and appropriate treatment or referral without conveyance has seen the paramedic profession more attractive to healthcare providers outside the historic core role.

The increased educational requirements and responsibilities of paramedics have positioned them as health professionals accountable for their practice who have evolved into an important group in the healthcare workforce capable of meeting patients' needs across a wide range of settings.

Physiotherapists

Physiotherapists are autonomous practitioners, with expertise in the use of physical and psychosocial approaches to rehabilitation, optimising independence and quality of life. Physiotherapy is a science-based profession and takes an evidenced approach to 'whole person' health and wellbeing.

Physiotherapists use a range of interventions including movement, physical activity, manual therapy, education and advice. Physiotherapists can acquire prescribing rights and train to inject or scan patients. Physiotherapists work with a wide range of patients including those with; musculoskeletal, cardiovascular and neurological conditions. Physiotherapists also contribute to and lead services for patients with cancer, dementia, mental health problems, chronic pain and incontinence. Physiotherapists work in many sectors and settings including, primary care, secondary and tertiary services, occupational health, public health, and social care.

Diagnostic and Therapeutic Radiographers

The radiographic workforce includes all levels of clinical practitioner from assistant practitioner, to consultant practitioner, senior educator, manager and research lead. Although predominantly registered radiographers, the workforce encompasses a number of individuals from other professions whose speciality lies within diagnostic imaging or radiation therapy.

Diagnostic radiographers respond to referrals mostly from other health professionals and employ a range of techniques to produce high quality images to diagnose an injury or disease. They are responsible for providing safe and accurate imaging examinations and often also the resultant report. The identification and monitoring of diseases, skeletal and soft tissue abnormalities and trauma are the major foci of diagnostic radiography. The interpretation of the images produced is central with specialist and advanced practitioner roles increasingly providing the definitive clinical report. Key patient outcomes include rapid diagnosis to facilitate effective timely treatment; abnormality and disease detection through screening and monitoring of therapeutic response.

Therapeutic radiographers play a vital role in radiotherapy services. They are the only health professionals qualified to plan and deliver radiotherapy using a wide range of technical equipment and they also monitor and follow up the use of ionising radiation for therapeutic purposes, predominantly the treatment of cancer, both curative and palliative. They constitute over 50 percent of the radiotherapy workforce working with clinical oncologists, medical physicists and engineers. Within radiation therapy, the radiographic workforce advanced practice roles include defining and adjusting radiation treatment to maximise effectiveness; determining and adjusting precise radiation dosage and supporting patients in managing the effects of therapy during and after the treatment period. Key patient outcomes include long term recovery, relief from symptoms and choice over management of treatment side effects.

Speech and Language Therapists

Speech and language therapists (SLTs) provide life-improving treatment, support and care for children and adults who have difficulties with communication, eating, drinking or swallowing. SLTs assess and treat speech, language and communication problems in people of all ages to help them communicate better. They also assess, treat and develop personalised plans to support people who have eating and swallowing problems. Using specialist skills, SLTs work directly with clients and their carers and provide them with tailored support. They also work closely with teachers and other health professionals, such as doctors, nurses, other AHPs and psychologists to develop individual treatment programmes.

SLTs play an important role in public health including screening and early identification of speech and swallowing difficulties. For example, they identify children with early language delays and provide targeted support to children with communication difficulties who live in areas of social disadvantage. SLTs also support the rehabilitation and enablement of people with acquired and developmental conditions, such as people with learning disabilities or individuals who have experienced a stroke. SLTs provide care for children and adults in community settings which helps to prevent unnecessary hospital admissions and decrease the need for crisis management of conditions such as dysphagia.

Appendix 2

AHPs commitments to the way services are delivered.

Appendix 2
AHPs commitments to the way services are delivered.

AHPs are already committed and will continue to be committed to high quality, person centered and sustainable care. This document demonstrates that they are innovators, they are flexible and are open to doing things differently.

These identified commitments to the way service are delivered demonstrate the strength of the AHPs offer across the system. They not only provide vital services to citizens when they are unwell but they recognise the necessity and responsibility of the importance of a broader view of disease causation and outcome, the biopsychosocial model.

Commitment 1:
Commitment to the individual.

Evidence informed, integrated, person centred, timely and easily accessible care delivered with the person receiving care central to the decision making which also includes family/partners/unpaid carers where appropriate.

Care will be person centred, delivered by an integrated team which includes family/partners/unpaid carers, offered throughout the life course, based on need not diagnosis. There will be no silo working/services reducing fragmentation and/or multiple transfers between different services. Care will be easily accessible by the ability to self-refer, where appropriate, to the most suitable professional to address the care need ensuring timely and equitable assessment and intervention. The overall aim for those receiving care, where possible and appropriate, is to selfcare/manage their own condition.

Assessment and intervention will be delivered using evidence based practice whereby the preferences and values of the person receiving care, the clinician's expertise (clinical judgement and experience) and the best available research evidence on whether and why a treatment is effective, are the principles applied in the decision making process.

This commitment is consistent with The Health Foundation's[17] description of person centred care, a framework that comprises four principles;

1. Affording people dignity, compassion and respect.
2. Offering coordinated care, support or treatment.
3. Offering personalised care, support or treatment.
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live and independent and fulfilling life.

Commitment 2:
Commitment to keep care close to home.

Care is accessible throughout life course and delivered primarily in communities.

The community will be the primary place where services are received. AHPs will lead those services supporting the reduction in demand on general practice (GPs), emergency and hospital services. The community could be the persons own home, primary care centre, ambulance station, leisure facility, education establishment or the local supermarket, for example. AHPs will be at the forefront of community care delivery.

Should hospital care be required, this should be one of seamless transition and not referral in to and out of, to ensure receipt of AHP intervention at the earliest possible stage of secondary care journey to best maximise the effect and efficiency of AHP intervention enabling return to the community at the earliest stage possible.

In 2014 The Kings Fund[18] described how community services can transform care. In summary, the key steps identified were reducing the complexity of services, wrapping services around primary care, building multidisciplinary teams with specialist support, creating services that offer an alternative to hospital stays, building an infrastructure to support this model of care, and developing the capability to harness the power of the community.

Such a model has been described by the National Association of Primary Care. Working in collaboration with NHS Confederation and NHS England, 15 test sites are building such models. The Primary Care Home (PCH) is a multispecialty community provider model with an integrated workforce with a combined focus on personalisation of care with improvements in population health outcomes.

Commitment 3:
Commitment to the health and wellbeing of populations.

Care also focuses on the health and wellbeing of communities.

Population health is as important as delivery of services to an individual to reduce spending on wholly avoidable diseases in the future. Care will utilise community assets to support communities to be both mentally and physically well through the use of flexible and innovative solutions. Care will utilise community assets to support communities to be healthy, happy and well and offer preventative interventions which reduce unwarranted ill health.

AHPs will work in collaboration with (if not already working for) other community services to ensure efficient and effective interventions. These will include public services e.g. fire, police, local authorities, education, but also third sector organisations.

Commitment 4:
Commitment to care for those who care.

Caring for those who care so that they are healthy and happy. Recognising, supporting and valuing the people who provide care to care is vital to the delivery of quality and efficient care no matter their role, paid or unpaid.

Recognising and valuing the people who provide care to care is vital to the delivery of quality and efficient care no matter their role in the team, paid or unpaid.

The workforce, no matter where they are employed or who they are employed by, is supported and utilised in the most effective way to deliver the vision. Developing and managing the professions, ensuring leadership at all levels and demonstrating the value of the skills and services AHPs deliver.

Promoting a culture that improves the health and wellbeing of employees is good management and leads to healthy and productive workplaces as evidenced in the NICE Workplace Health guidance[19].

"Is this about carers or AHPs? It is both and more. It is about those who are delivering care as part of the team, including the person receiving care and unpaid or paid carers and professionals. AHPs already demonstrate their ability to understand and think wider than physical health/ill health. This commitment is demonstrating this understanding of the needs of others and those of your own such that when and where it is appropriate and possible we offer our skills to ensure those who care are cared for as equally".

Anon: July 2016. Direct quote; contributed to phase two of AHP online workshop.

Appendix 3

AHPs priorities to meet the challenges of changing care needs.

Appendix 3
AHPs priorities to meet the challenges of changing care needs.

Alongside being committed to high quality, person centred and sustainable care and being open to doing things differently, for AHPs to play their part in transforming care they need the right support across the system. The four priorities describe what is required to meet the challenges of changing care needs.

Priority 1:
AHPs can lead change.

'AHPs into Action' offers permission to AHPs to propose change and to be engaged at all levels of decision making within the system, from the care team, to trust boards through to national and international forums. Stakeholders need to recognise that AHPs can be effective leaders at all levels and in all sectors.

To deliver change across the system AHPs should be encouraged and facilitated to fill formal leadership positons alongside doctors, nurses and managers. This would result in a more balanced inter-professional representation within management structures. A bigger AHP presence in senior positions will aid change and engagement with AHPs.

AHPs should be represented in the decision making processes for STPs to ensure they have a strong voice in the redesign of health, social and the wider care system. Their focus on the patient/client/service user will encourage more flexible care provision delivered most cost effectively.

"Is this not about 'leadership' rather than leaders. It's not about roles and titles but about demonstrating attitudes and behaviours at all levels - leadership is a whole workforce approach".

Anon: July 2016. Direct quote; contributed to phase two of AHP online workshop.

"We need to think about tomorrow's leaders as well as today's - at all levels. This is a massive point, we need to ensure that our next generation of AHP leaders are identified quickly and are fast tracked into meaningful programmes that place them on par with other professions".
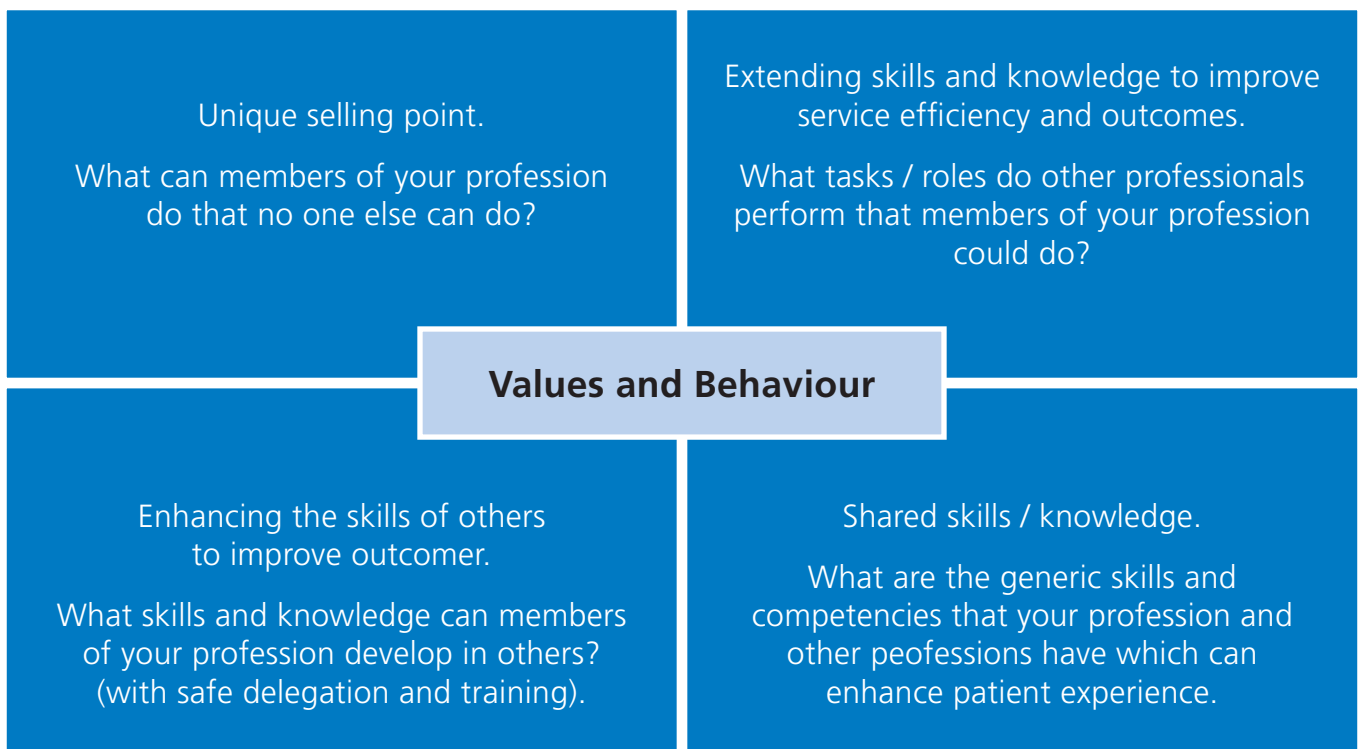
Anon: July 2016. Direct quote; contributed to phase two of AHP online workshop.

Priority 2:
AHPs skills can be further developed.

To achieve the Five Year Forward View's ambitions, a broader multi-professional workforce is required. It will work in ways that optimise productivity and efficiency while maintaining the focus on improving quality[10]. Traditionally AHPs have been regarded primarily as experts in their clinical fields. Increasingly AHPs are developing wider skills which complement their specialisms and provide flexibility.

Developing the existing workforce is vital for trusts to meet the changing needs of patients and to deliver what is required for future care[20]. In order to achieve this, the crowd identified four areas of notable significance to ensure a state of readiness to deliver the workforce for future care.

State of readiness for future care

Unique selling point. What can members of your profession do that no one else can do?	Extending skills and knowledge to improve service efficiency and outcomes. What tasks / roles do other professionals perform that members of your profession could do?
Values and Behaviour	
Enhancing the skills of others to improve outcomer. What skills and knowledge can members of your profession develop in others? (with safe delegation and training).	Shared skills / knowledge. What are the generic skills and competencies that your profession and other peofessions have which can enhance patient experience.

Unique selling point - What can members of your profession do that no one else can do?

Individually each AHP profession brings a unique core skill set which is important to recognise and define as a crucial part of the wider multidisciplinary team. As well as their individual roles, AHPs are a vital part of integrated teams because skills are well suited to working in an integrated, biopsychosocial model.

Extending skills and knowledge to improve service efficiency and outcomes - What tasks/ roles do other professionals perform that members of your profession could do?

To meet the changing needs of patients, and to deliver what is required for future care, health and care professionals need to continue to develop their skills to higher levels. Some AHP professionals are already able to train as prescribers. More AHPs should be able to consider the relevance of medicines supply mechanisms, including prescribing within their scope of practice[21].

AHPs offer solutions to workforce challenges and are pushing out of traditional environments and into new ones. Advanced Practice frameworks are emerging that are inclusive of AHPs. General practice, extended scope and consultant roles are developing and specialist nurse roles could be undertaken by AHPs, adding depth to the team, and new avenues for professional development.

Enhancing the skills of others to improve outcomes - What skills and knowledge can members of your profession develop in others (with safe delegation and training)?

The education systems and employers need to support AHPs to share their skills. It is increasingly common for AHP students to share elements of training, not only with other AHPs but also with student nurses and doctors. This is to be encouraged.

Support staff are highly valuable in supporting the work of AHPs. There is good evidence that support workers can provide good quality, patient focused care as well as reduce the workload of more highly qualified staff[20]. The numbers of support workers in AHP led services are likely to need to grow. Many professions utilise non-registered staff effectively however, there is scope to develop this workforce further. Investing to upskill the AHP support workforce will free time for the registered AHPs and potentially other professionals to work to optimal productivity.

**Shared skills/knowledge - ** What are the generic skills and competencies that your profession and other professions have which can enhance patient experience?

All health care professionals need to be aware of each other's skills and abilities to facilitate multidisciplinary working and integrated care, and to prevent duplication of services. It is important that both professions and the public work together to form a collaborative approach to the delivery and re-design of care service.

> "The AHP professions are all unique and each has so much to add. But what we really must stop doing is fighting against each other by fighting integration of services. There is a lot of overlap in our assessments and intervention - we need to agree to collaborate on the elements that we all cover to avoid duplication, trust each other's assessments and focus on adding extra value rather than redoing what our colleagues have already done. AHPs need to stop referring to each other across the 'boundaries' of acute/community care and start sharing our assessments, goals and treatments with each other. This will avoid repetition, save everyone's time, and benefit patients".
>
> Anon: April-May 2016. Direct quote; contributed to phase one of AHP online workshop.

Values and behaviour

If the focus is on the need and not the diagnosis and there is more flexible approach, care provision would better match need. AHPs are receptive, open to change and offer innovative solutions to doing things differently.

> **"Exploit our AHP genius in joining dots. Bring people together around an issue/person/community bringing the best of all sectors acute community primary care voluntary sector, private sector, local authority, housing ....we all have a jigsaw piece to offer. We need to build our networks and craft the revolution! Or for those of us doing it already keep at it and stay nimble to make sure your work fits as many people's jigsaws as possible as the world changes around us".**
>
> Anon: April-May 2016. Direct quote; contributed to phase one of AHP online workshop.

Priority 3:
AHPs evaluate, improve and evidence the impact of their contribution.

AHPs, service providers and commissioners need to collect and evaluate evidence of clinical and costs effectiveness. There needs to be routine collection of consistent and comprehensive data on the impact of AHPs on the quality of care to individuals and populations.

AHPs need to demonstrate both the quality and the cost effectiveness of the services they provide individually and collectively within integrated teams. Quality Watch[22], recognised that AHPs, despite the size of the workforce and the broad scope of care, do not routinely collect consistent and comprehensive data on the impact they have on the quality of care to populations. Although many AHPs collect data routinely as part of clinical practice there is no standard way of demonstrating the value that AHPs bring to services for individuals and populations.

> **"A culture underpinned by a strong commitment to evidence based practice and the promotion, use and conduct of research".**
>
> Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop.

Support is needed to develop the capability and capacity to undertake cost analysis.

Research active AHPs help to: strengthen the services they offer, use AHPs time more efficiently and effectively, and demonstrate value. Programmes to develop and maintain the skills to read, interpret and critique research will help AHPs to make more informed choices about applying evidence in practice. Research trials organised at a national level are required to research the clinical and cost-effectiveness of multidisciplinary and multiagency intervention packages.

"This focus represents a truly ambitious and essential goal. You cannot cost your services and assert authoritative claims to health outcomes if you don't have a national minimum data set that every professional in every profession works towards within an agreed overarching allied health framework".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop.

"It is more about ensuring that we all recognise and value the importance of measuring outcomes, that we share an understanding of the importance of reporting on these outcomes and that we are given the time and space to conduct research to support evidence based practice".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop.

"Developing a culture that strives to assess and demonstrate the effectiveness and impact of everything we do, using this to continuously improve what AHPs do as well as demonstrate our value".

Anon: July 2016. Direct quotes; contributed to phase two of AHP online workshop.

Priority 4:
AHPs can utilise information and technology.

The utilisation of informatics, including evidence data described in priority 3 above, is crucial in order to make good decisions for the delivery of quality and efficient care. AHPs need to access the tools to support their use of informatics.

In 2015, NHS Improving Quality, the University of Leeds and NHS England[23] hosted a round-table discussion with local, regional and national practitioners to explore the barriers and solutions to effective use of informatics in delivering patient care. The report recommended that informatics should form part of core training, registration and daily work.

Advances in technology are equally important because of the 'paper-free at the point of care' ambition in the Five Year Forward View. Advancing technology also offers treatments to citizens, families and the public in a very different way and offers huge opportunities for learning and development. Clinically led improvement, enabled by new technology, is transforming the delivery of health care and our management of population health[24]. Working with AHPs to develop appropriate technologies should be a priority.

Appendix 4

AHPs case studies; innovative solutions.

Appendix 4
AHPs case studies; innovative solutions

These case studies illustrate the range of AHP services and the diversity of solutions they can deliver to meet local population needs.

Case Study 1:
Stoke Speaks Out - A multiagency approach to tackling high incidence of speech, language and communication needs across a whole community.

Understanding the problem

Local research in 2002 indicated that upwards of 64 percent children were entering nursery in Stoke on Trent with significantly delayed language skills. This impacts on all aspects of children's development and can reduce their life chances. The core speech and language therapy service was receiving a high level of referrals- many of which could have been dealt with at a universal or targeted level if the children's workforce were more informed. A multiagency programme was set up led by a speech and language therapist to develop an approach which included training, development of resources, system change and influencing strategy. The aim was that if the workforce had enhanced skills, knowledge and confidence in this area there would be fewer children requiring the specialist NHS provision. This would also reduce waiting times and access for those who truly needed the specialist services. Supporting a universal and targeted level would be able to reach a wide workforce with limited team and therefore cost saving.

Aims and Objective

To increase the number of children reaching age related milestones in speaking and listening by the age of 3 years.

To increase the confidence and competence of the children's workforce to be able to support speech, language and communication needs at a universal and targeted level.

To provide consistent messages and resources around early communication.

To evaluate what works in tackling wide scale communication difficulties.

Method and approach

A multiagency team was developed to investigate what needs the local communities had and to set a baseline. They developed a five tier training framework for delivery to multiagency groups (this has reached over 6000 practitioners to date). Tools were developed to support system change e.g. a 'staged pathway' to support decision making around referrals to speech and language therapy. A child development tool was put in place to build confidence in making judgements around

children's development. A strong public health messaging campaign was developed to ensure consistent messages were used across all communities. Speech, language and communication was put onto all local strategic agendas as a priority to ensure whole system take up e.g. children's plan. Children's progress in speech, language and communication has been continually measured to monitor the effectiveness of the work. The main barrier has been changes in staffing and structure within the children's workforce and short term funding which has not acknowledged that this is generational change and will need long term investment to save.

Results and evaluation

Initial baseline figures in **2002 indicated 64 percent** children age 3 years were delayed. This was measured every three years and by **2010 this was down to 39 percent** delay. In 2010 funding was cut and there was significant reduction to children's services. The 2013 measure showed that the cuts impacted on children's language and the 2013 measure **rose to 46 percent delay**. This evidence has supported re-investment by the city council from 2015-2019 as part of a 'school readiness' plan. The core NHS service works seamlessly with this approach and has developed a triage system which checks that referrers have followed the 'staged pathway' prior to referral and on assessment gives a risk score on what the speech and language therapist can uniquely provide. Currently all private nurseries and schools are being trained to screen early language from age 2 years and are being trained in targeted packages to meet the needs of many children. This will reduce the need for the three yearly city-wide assessment of children as the data will be submitted annually from the settings.

Key learning points

Identifying the problem required time out of core business and a robust measure. Once the problem was identified it needed communicating with strategy makers and service developers. Universal and targeted work can make significant impact but this needs ring-fenced investment and is not a quick fix. The model is transferable to other aspects of care. Investing in specialists working at universal level is cost saving to specialist services and should be considered as part of whole service delivery.

Plans for Spread

Stoke Speaks Out has won many national awards including 'Shine a light' award, Children Now award, Practical Pre-school award, Early Years educator and the local Trust 'celebrating excellence' award. We regularly provide case studies and information for Royal College of Speech and Language Therapists and policy makers.

Key Contacts

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Commissioned by Stoke on Trent City Council from Staffordshire and Stoke on Trent Partnership Trust NHS Trust.

Case Study 2:
Population based research influencing children's eye care.

Understanding the problem

Early screening programmes can only be effective if children identified with poor vision are treated. Data obtained from local research and audit of the vision screening outcomes has shown a significant rate of fail to attend. Therefore a high proportion of children with identified needs do not access ophthalmic services and subsequent appropriate treatment. Little is known as to the reasons.

Aims and Objective

Aim: To determine the visual status of 4-5 year old children on school entry and relate this to their uptake of eye care services and their emerging literacy skills.

Objectives:

- To determine the impact of failing to access treatment for reduced vision on emerging literacy skills.
- To determine factors associated with non-attendance and explore reasons for non-participation in eye care.
- To devise a service model aimed at improving the uptake of eye care services in children identified as having visual health care needs.

Method and approach

By linking data from the local vision screening programme to measures collected from mothers and children participating in the Born in Bradford, cohort study measures of vision, literacy as well as attendance have been collected. Barriers to accessing ophthalmic services have also been explored by interviewing parents/carers to discover attitudes, practicalities and health beliefs which may influence the treatment of visual health and attitudes and experiences of using health services.

Results and evaluation

The information regarding non-participation will be used to design new approaches to service provision, improving access to children's ophthalmic services; this will inform service delivery both locally and nationally. At this stage it is uncertain as to what the evidence will be and the form of the service re-design. Possibilities include revising or targeting information for certain groups, providing services in an easily accessible location, such as the school itself or a more effective one-stop shop service in the community.

Key learning points

Engaging with this parent group has been difficult and it has only been with the support of the local schools that parent interviews have been possible. Schools and teachers are key in engaging with parents.

Plans for Spread

The research evidence will be used to influence service provision both in the community and in the Hospital Eye Service and a revised model/will be recommended with the aim of reducing inequalities to access and improving participation in health care.

Key Contacts

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Case Study 3:
Embedding a health promotion strategy across musculoskeletal (MSK) physiotherapy in Salford.

Understanding the problem

- Salford has some of the worst health in the country and large health inequalities.

- AHPs being driven to optimise health promotion interventions.

- Many MSK problems e.g. osteoarthritis, low back pain, tendinopathies etc. are influenced or caused by health and lifestyle choices e.g. weight, physical activity, smoking, mental health issues.

- Health promotion and prevention practice in physiotherapy and MSK services was sub-optimal, patchy and not seen as a priority.

- Physiotherapy undergraduate education leading and developing public health practice yet this is not always modelled in clinical practice.

Aims and Objective

This project aims to directly improve the health of people in Salford via an increased focus on prevention and facilitating positive health behaviours within physiotherapy through partnership working with Salford Public Health and Salford National Diabetes Prevention Programme (NDPP).

Method and approach

- All patients attending MSK services will have prevention at their core with BMI / BP, smoking, alcohol and physical activity status' measured and recorded. NHS health checks and diabetes screening will be provided where appropriate.

- Creating an environment for patients and staff which foster a culture of health promotion with training and ease of access to health promotion information and smooth transition to community services.

- Develop firm partnerships with public health and community services.

Results and evaluation

From an audit of 70 physiotherapy records, baseline data saw that less than 2 percent of records had documented smoking, alcohol or weight recorded. Less than 50 percent had physical activity levels recorded and no records documented referrals to health promotion services e.g. smoking cessation.

Qualitative evaluation of physiotherapy staff showed low confidence in tackling some health issues including weight management, alcohol and smoking cessation.

Project evaluation will measure the following at six month and twelve months;

1. Recorded data including BMI, BP and other health data and associated healthy conversations and referrals to health promotion partners.
2. Number of NHS Health checks completed and associated data.
3. Number of patients identified as pre-diabetic patients in line with Salford's National Diabetes Prevention Programme (NDPP)
4. Evaluations of patient's experiences of receiving health assessments and NHS health checks as part of physiotherapy appointments.
5. Physiotherapists' attitudes towards implementation of health promotion strategy and interventions.
6. Case studies will be used to illustrate changes to patient's lifestyle, health or wellbeing.

Key learning points

Work in partnership with as many agencies and providers as possible to maximise impact from interventions and avoid duplication. For example, this project has aligned with NDPP and also Public Health, providing NHS health checks alongside providing health assessments in physiotherapy. Work with commissioners to meet health and wellbeing needs of community.

Plans for Spread

Dissemination of projects through conferences and networks e.g. social media, Chartered Society of Physiotherapists and their members. Data will be presented for publication and dissemination at end of one year pilot.

Key Contacts

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Case Study 4:
'Eat, Drink, Move!' Supporting people to keep well during hospital admission.

Understanding the problem

Hospital inpatients often experience poor appetite and reduced food intake due to illness, anxiety, confusion and periods of 'nil by mouth'. Fluid intake can also be poor for similar reasons. This is well recognised and has been widely promoted for many years. Robust systems are in place at Heart of England NHS Foundation Trust (HEFT) to ensure effective nutritional screening takes place and active support is provided to improve food and fluid intake in those at risk. These measures are essential to reduce the impact of poor nutritional status and dehydration in hospitalised patients. It is less well recognised that physical activity levels can also be minimal in hospitalised patients and this also has significant clinical impact, increasing risk of pressure sores, blood clots, pneumonia and, particularly in frail older people, quickly reducing physical functional capacity and confidence to cope independently with activities of daily living.

Keeping patients mobile in hospital reduces risk of pressure ulcers, falls, blood clots, chest infections and length of stay, supporting harm free care, with significant benefits to clinical outcome and cost of patient care[1,2]. Physical activity can be encouraged and increased in hospital using simple measures, even in those who need support to mobilise safely. There are natural links between measures to increase mobility and those used to promote good nutrition and hydration, supporting a wider focus on maintaining functional capacity in hospital, advocated by Therapy teams.

[1] Whitlock J. SSKIN bundle: preventing pressure damage across the health-care community. Surface, Skin inspection, Keep moving, Increased moisture management, Nutrition. Br J Community Nursing, 2013 Sep: Supplement: S32-9.

[2] Nolan J, Thomas S. Targeted individual exercise programmes for older medical patients are feasible, and may change hospital and patient outcomes: a service improvement project. BMC Health Serv Res. 2008;8:250. Epub 2008/12/11.

Aims and Objective

To develop and evaluate simple measures (a 'mobility bundle') to promote increased mobilisation of inpatients in an acute hospital setting. To promote the mobility bundle aligned to existing initiatives to promote good nutrition and hydration for inpatients as an overarching Therapy-led project 'Eat, Drink, Move!' The aim of the initiative was to support health, wellbeing and recovery from illness and to maintain physical functional capacity as far as possible during an acute hospital admission and to promote the benefits of keeping nourished, hydrated and mobile as part of a long term healthy lifestyle.

Method and approach

Development of resources:

A mobility bundle has been developed by the physiotherapy team. This consists of:

- Initial assessment of mobility, manual handling needs and falls risk as part of nursing assessment on admission and during a hospital stay.

- A mobility chart used by therapists to record clearly how a patient can safely mobilise as their therapy progresses.

- Promotion of simple measures to be used at ward level to encourage patients to mobilise more,

with support where needed, where this can be done safely. For example walking to the toilet instead of using the commode, walking to the food trolley to choose meals, walking to the door to meet visitors. Patients are also encouraged to dress in day clothes rather than pyjamas where possible so they are less inclined to feel they must stay in bed.

- A short information booklet for patients and carers promoting simple ways to eat, drink and move more in hospital.

Training for ward staff:

Therapy staff (physiotherapy, occupational therapy, dietetics and speech therapy) led, promoted and supported this initiative. The mobility bundle was developed in close collaboration with nursing staff and therapy teams; it was used on trial wards initially, and then later on other wards to support roll out. Training and promotion has been focussed at ward level to raise awareness and increase skills and confidence to use simple measures to increase mobilisation while maintaining patient safety. Training has been delivered day to day at ward level 'on the job by therapy staff, avoiding the need for nursing staff to be released from the ward.

Trialling of the mobility bundle

Promoting the results, roll out across the trust and ongoing promotion:

Positive clinical results were publicised to therapy, nursing and medical staff. This secured good engagement for roll out. Launched at a 'Harm free care' day focussed on 'Eat, Drink, Move!'

The approach of rolling out the mobility bundle linked with measures to promote nutrition and hydration, promoted as the wider initiative Eat, Drink, Move! has been taken to capitalise on the good staff engagement and robust monitoring systems that already support these well embedded aspects of care.

Ongoing and repeated ward level promotion and training supported by Therapy staff is embedding this initiative in routine ward practice. Inclusion of monitoring measures in routine ward metrics supports compliance. All opportunities are taken to promote Eat, Drink, Move to support trust priorities e.g. reducing falls risk, tissue viability, reducing length of stay, and admission avoidance by linking with community units and residential care settings. Promotion is linked to other events e.g. Nutrition and Hydration week, Falls Prevention week, National Older People's Day.

Results and evaluation

A trial carried out at HEFT demonstrated that introduction of a 'mobility bundle' consisting of simple measures to increase physical activity in inpatients was effective in increasing simple mobilisation and in our study reduced the incidence of hospital acquired pneumonia on intervention wards by 50 percent. The trial conducted with medical and nursing colleagues at HEFT in 2013[3] implemented the 'mobility bundle' on 2 medical wards (n=678 patients), comparing activity and outcomes with 2 matched wards (n=501 patients). Patients on intervention wards showed increased activity (Intervention: 83.1(44.9) minutes per day, 1103(103.8) steps count/day. Control: 40.5 (26.8) minutes per day, 388 (90.5) steps count/day), halved incidence of hospital acquired pneumonia (HAP) (p<0.0001) and were more likely to have a length of stay in the shortest quartile.

[3] M Stolbrink, L McGowan, H Saman et al, The Early Mobility Bundle: a simple enhancement of therapy which may reduce incidence of hospital acquired pneumonia and length of hospital stay. J Hosp Infect 2014 Sep:vol 88;issue1;p34-39

Key learning points

Simple measures to increase mobilisation in hospitalised patients can improve clinical outcome, reduce risks associated with inactivity in hospital, and reduce length of stay.

System changes can be achieved more easily by linking onto already successful approaches. Longstanding promotion and ongoing training had already ensured good awareness amongst ward staff of the need to maintain good nutrition, hydration. There was less focus on the importance of maintaining mobility and perceived risks and lack of nursing time were potential barriers to implementation. Linking nutrition, hydration and mobilisation as part of a wider approach to help patients keep well in hospital delivered good interest and engagement. Ward level training and promotion has been used to raise awareness and increase engagement, skills and confidence to use simple measures to increase mobilisation while maintaining patient safety.

The workforce leading the project were registered physiotherapists, occupational therapists dietitians, and speech therapists with good understanding of the benefits of the project and the skills to train and support ward staff. High levels of engagement were secured from corporate nursing and monitoring of compliance was measured using robust nurse-led metrics.

Critical success factors for this project were;

• demonstrating the clinical benefit of increased mobilisation

• aligning the project to other successful initiatives and working methods

• taking training to ward level and delivering and promoting repeatedly 'on the job' not depending on release of staff for one off training

• building in to robust monitoring methods to secure compliance and sustained high profile.

Plans for Spread

Poster presentations given at professional conferences in 2014 (British Association of Parenteral and Enteral Nutrition and at CSP)

Local sharing across the trust including more recently sharing with community units as the same messages are highly applicable in nursing and residential care.

Key Contacts

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Case Study 5:
An NHS workforce 'fit' for purpose: influencing physical activity through social media.

Understanding the problem

It is well known, despite compelling evidence for the benefits of physical activity on the health of the workforce, that achieving uptake and sustained activity across the global population is complex. The #WeActiveChallenge has shown that social media can be a useful tool to support networks of individuals who, through their own efforts, motivate others to do more than they did before and role model healthy lifestyles.

Aims and Objective

WeCommunities connect, drive and support tweeting communities. It is run by healthcare professionals who believe passionately that through linking people and sharing information, ideas and expertise we can share best practice and ultimately provide better care.

Clear, simple objectives were developed for the #WeActiveChallenge and shared with the communities:

- Raise the profile of the importance of peer support and role modelling in physical activity.
- Practice what we teach/preach as health and care staff.
- Motivate, inspire and create a sense of community.

Method and approach

In 2015 the #AHPsactive campaign which took place across July and August and the #AHPsActive Vs #NursingActive competition during the last two weeks in August enthused allied health professional colleagues and nursing counterparts to fill Twitter with pictures and tweets about health and care workers getting active. Over 750 participants reached 12 million people through the campaign. 2016 grew from this momentum, with eight of the WeCommunities participating during the month of August in #WeActiveChallenge; nurses, AHPs, Police, Commissioners, Finance, Midwives, Doctors and Pharmacists. This year, to encourage healthy competition, an online leader board was introduced so that communities would be motivated by seeing others efforts and by the chance to earn virtual bronze, silver and gold medals.

Results and evaluation

The 2016 competition involved 3,150 people who tweeted 19,393 tweets of which 4029 included inspiring photographs of their efforts. Many of those involved tweeted about the impact it had, had for them personally:

- @WeNurses we have loved the #WeActiveChallenge so much that the Wednesday afternoon walking group is here to stay!!!!
- Thank to @WeAHPs for active challenge. Still continuing, joining a running club tonight.
- #AHPsActive last day of August. Loved the challenge and met my target of running or hiking 100km (+ many many flights of stairs).

Key learning points

Social media is a useful tool in supporting behavioural change through engaging people in networks of communities which provide support, learning opportunities and motivation. Such initiatives need to be:

- planned carefully, with clear focus and objectives
- facilitated, with clear instructions how to take part, and monitored
- supported by professional guidance on the use of social media.

Plans for Spread

We would like to build on the 2015 and 2016 efforts so that in 2017 more people will be motivated and inspired to role model healthy lifestyles. We want to see healthcare workers continue to challenge themselves (and others) to do a little bit more than before because #WeActiveChallenge is about caring for ourselves so we can care for others.

Key Contacts

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Case Study 6:
Fitness For Work Service.

https://www.england.nhs.uk/challengeprizes/about/winners/winners-1415/fitness/

Case Study 7:
Occupational Health Service reducing absence rates.

http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-works/occupational-health

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Case Study 8:
Move Away from Prediabetes (MAP).

Understanding the problem

Prediabetes is a pre-diagnosis of diabetes, which indicates a patient is at high risk of developing Type 2 diabetes unless steps are taken. Diabetes prevalence is expected to reach 15 percent of the adult population by 2030 unless steps are taken.

Aims and Objective

MAP is a free, innovative behaviour-change programme led by dietitians and designed to help those diagnosed with prediabetes to move away from the condition in a self-managed way. MAP draws on research from randomised controlled trials in the US and was developed in line with NICE guidance on the prevention of Type 2 diabetes. Its aim is to move people out of a diagnosis of prediabetes by helping them achieve a healthy weight, more active lifestyle, healthier diet and improved blood pressure, blood glucose and cholesterol levels.

Method and approach

Based in leisure centres (rather than a healthcare setting) it consists of four one-to-one sessions with a dietitian and a number of group sessions providing dietary and exercise advice over the course of six months. Content is culturally appropriate and inclusive and includes interpretation where necessary (especially important in a diverse area such as Brent).

Participants receive an initial written profile including their blood test results, height, weight, waist circumference, body fat percent and blood pressure. These results are explained to them in a one-to-one with a dietitian, and this then forms the foundation of self-management (further blood tests and measurements can be taken to track progress). SMART goals are decided upon and set by the patient.

Patients are provided with three months free gym membership and are provided with structured physical activity sessions with qualified fitness instructions. They are also encouraged to reduce portion sizes, better understand the content of food and practice mindful eating.

Results and evaluation

The MAP programme has used a robust process of clinical assessment over the course of the four years it has run. Patients are encouraged to return for follow ups at 6 and 18 months to reflect on success and monitor changes. It has a high completion rate of 72 percent compared to similar lifestyle programmes. 60 percent of patients have moved out of a prediabetes diagnosis, 81 percent have improved glycaemic control and reduced their waist circumference and weight by the end of the programme. At 12 months, 43 percent remain out of a prediabetes diagnosis.

Key learning points

Fit4Life Brent has expanded upon the success of the programme to meet the full parameters of the NHS Health Check and prevent not just diabetes but associated health conditions such as heart and kidney disease and stroke.

Having access to translation/interpreters has been essential in an area with a high proportion of the population from a non-English speaking background.

Plans for Spread

The success of MAP has seen two further programmes commissioned; MAP Hounslow and Fit4Life Brent. The programme has also be shared by the British Dietetic Association through channels such as Dietetics Today, and has received national recognition in Diabetes UK's Diabetes Update.

Key Contacts

Farhat Hamid, Head of Nutrition and Dietetics, Brent, London North West healthcare NHS Trust
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Case Study 9:
Diabetic Foot Screening App.

Understanding the problem

The College of Podiatry recognised the need to commission a piece of work to assist health care practitioners and health care assistants in screening the feet of people with diabetes in order to reduce the risk of them developing avoidable complications, such as ulceration, infection and possible amputation.

To ensure the benefit of the person with diabetes ultimately at the forefront of consideration, and to allow for a holistic approach to be taken, the College of Podiatry had also recognised the need for pertinent patient information to be available and accessible, regardless of the age or location of the person with diabetes or the person performing the foot screening.

Foot complications are common in people with diabetes. It has been estimated that between 5-7 percent of people with diabetes have current or previous foot ulceration. Diabetes is the most common cause of non-traumatic limb amputation, with diabetic foot ulcers preceding more than 80 percent of amputations in people with diabetes. After a first amputation, people with diabetes are 23 times more likely to have a further amputation than people without diabetes. Mortality rates after diabetic foot ulceration and amputation are high, with up to 70 percent of people dying within 5 years of having an amputation. Around 50 percent die within five years of developing a diabetic foot ulcer. This high mortality rate is believed to be associated with cardiovascular disease, and emphasises the importance of good diabetic and cardiovascular risk management. Foot problems in people with diabetes have a significant financial impact on the NHS. A report published in 2012 by NHS Diabetes estimated that around £650 million (or £1 in every £150 the NHS spends) is spent on foot ulcers or amputations each year.

It is quoted that 10 per cent of the entire NHS budget is spent on diabetes every year, 80 percent of which goes toward treating the secondary complications (the vast majority of which are related to diabetic foot issues). This does not take in to account the cost of amputee rehabilitation and the lifelong care and management.

Improved quality of diabetic foot screening, referral pathways and standardised patient information will lead to a reduction in unnecessary foot complications, ulceration, amputations and improved management of diabetes along with huge savings to the NHS.

Aims and Objective

The app has been developed from a unique multidisciplinary collaboration to provide the following:

For health care professionals:

- An understanding of the importance of routine foot screenings.
- An understanding of how diabetes affects the feet.
- Details of how to perform a quality diabetic foot screening.
- Information of how to determine the patient's risk status.
- Pertinent patient education.
- Information of when a referral is required and whom a referral should be sent to.

For people with diabetes:

- An understanding of the importance of routine foot screenings and how diabetes can affect the feet.

- Information of what to expect from a quality diabetic foot screening.

- An understanding of what their risk status means.

- Pertinent patient education specific to their current level of risk.

- The ability to store emergency contact details and future appointments.

- Details of when to seek advice.

Method and approach

Through a unique multidisciplinary collaboration, the College of Podiatry worked with the British Association of Prosthetists and Orthotists (BAPO) and Foot in Diabetes UK (FDUK), the College's multidisciplinary special advisory group.

A full literature review was initially conducted, with a review of all available screening methodologies, tools and education platforms currently available. Work was then carried out with FDUK to write evidence-based content for the app.

A clearer vision and sense of responsibility in relation to diabetic foot risk stratification assessment and management interventions outside of wounds and surgery and specific guiding principles on initiating and reviewing best treatment in relation to modifiable risks with the diabetic population are at the heart of this work.

Key learning points

Barriers encountered were twofold. Firstly, recognising that the app would not be able to ensure a practical-based competency of the healthcare professional in performing the screening. To combat this, a parallel classroom based teaching platform has been developed using the same language as the App, which comprises of both a theoretical and practical examination.

The other barrier was recognition of the fact that not all healthcare professionals would have access to a hand-held tablet/phone during a clinical appointment in order for the app to be used. In order to ensure that the tools available are universal and available for as many professionals as possible, a downloadable desktop-based programme has been developed for people to use in clinical environments, from which electronic reports can be generated which can be uploaded into patient electronic records, or printed for patient files to provide supporting information for any onward referrals.

Results and evaluation

The app is due for launch in October 2016.

Key learning points

We intend to publish a how to write a health app guide, which will ensure others do not come up against the same problems.

Plans for Spread

Parliamentary launch, and to publicise through nursing, AHP and diabetes related publications.

Key Contacts

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Christian Pankhurst, Clinical Specialist Orthotist, Guy's and St. Thomas' Community Rehabilitation Services, Orthotics Department. Email: Christian.pankhurst@nhs.net

Matthew Fitzpatrick, Provost of The College of Podiatry. Email: m.fitzpatrick@nhs.net

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Case Study 10:
Fixing foot care in Sheffield.

https://www.diabetes.org.uk/Documents/Footcare%20Case%20Study%201-%20Improving%20the%20pathway%20in%20Sheffield%20(February%202015).pdf

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Case Study 11:
Waistlines - an integrated tier 2/3 dietetic-led adult weight management service.

Understanding the problem

Obesity impacts on health, associated healthcare costs and quality of life. Data from 2012 showed that Staffordshire has an obesity rate of 24.4 percent which is higher than the national average of 23 percent. The Waistlines service was commissioned to support those with a BMI of ≥28kg/m2 to lose weight and maintain weight loss. As well as non-complex patients, those with complex needs and clinical conditions were also supported in the service. Links with local bariatric services enable referral on for surgery where appropriate.

Aims and Objective

- To support patients to achieve and maintain 5% weight loss.
- To increase fruit and vegetable intake.
- To increase knowledge of healthy eating and strategies to achieve and maintain healthy lifestyle change.

Method and approach

A service was designed to support both tier 2 and 3 patients across South Staffordshire. The intervention provided one to one appointments with optional access to group workshops, drop-in weighing, physical activity and cook and eat workshops. Patients saw a dietitian, weight management advisor/practitioner, physical activity practitioner or a combination depending upon clinical complexity and individual need.

Results and evaluation

Of those completing the 12 month programme 40.4 percent (n=394/975) achieved ≥5 percent weight loss at discharge (p<0.001). A mean increase of 8 portions of fruit and vegetables per week was achieved (p<0.001), with 53.2 percent (n=536/1008) consuming 5 or more portions per day compared to 19.8% (n=200/1008) at baseline (p<0.001). There was a mean reduction in alcohol intake of 6.4 units per week in those who consumed alcohol at baseline (n=409, p<0.001).

5 percent weight loss outcomes at 12 months were higher (40.4 percent) than in all services evaluated by Jolly et al (2011) where Weight Watchers showed the best result (31 percent). 5 percent weight loss was achieved in 28 percent of patients at 18 months in an NHS complex weight management service reviewed by Louge et al (2014). Patient groups in these studies were not directly comparable due to varying patient complexity and co-morbidities, but results indicate that Waistlines achieved better outcomes. Improved dietary intake resulted in a significant increase in numbers achieving at least 5 portions of fruit and vegetables per day and a significant reduction in alcohol intake, thus improving public health outcomes.

Patient feedback indicated a high level of satisfaction with the service and comments included indication of long term intention to maintain change. Improvements in cholesterol levels and blood pressure were reported with associated reduction in medication as a direct result of weight loss and increased activity levels, thus impacting positively on healthcare costs.

Key learning points

This service achieved significant weight loss and public health outcomes linked to dietary improvement. This may be a result of tailored, multicomponent support with a focus on behaviour change and dietetic leadership/supervision.

NHS England (2014) recommended commissioning of tier 2 adult weight management services by local authorities and tier 3 by clinical commissioning groups. The results achieved by Waistlines indicate that this may not be a positive move, particularly when tier 2 patients will no longer receive dietetic input.

Plans for Spread

Early data was awarded with Best Service Evaluation at BDA Research Symposium 2014 and abstract published in Journal of Human Nutrition and Dietetics March 2015.

There are plans to write this service evaluation up for publication in a peer reviewed journal.

Key Contacts

Liz Humphreys, Advanced Dietitian Team Lead, Staffordshire and Stoke on Trent Partnership NHS Trust. Email: Elizabeth.humphreys@ssotp.nhs.uk

References

Jolly, K., Lewis, A., Beach, J., Denley, J., Adab, P., Deeks, J., Daley, A., Aveyard, P. (2011) Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten Up randomised controlled trial. **British Medical Journal** 343:d6500.

Logue, J., Allardice, G., Gillies, M., Forde, L., Morrison, D. (2014) Outcomes of a specialist weight management programme in the UK National Health Service: prospective study of 1838 patients. **British Medical Journal** 4:e003747.

NHS England (2014) Report of the working group into: Joined up clinical pathways for obesity. **NHS England**.

Case Study 12:
Working with early years education settings to inspire children and families to lead healthier lifestyles.

Understanding the problem

In Luton levels of tooth decay are well above the national average for reception aged children. In the latest National Child Measurement Programme data 21.4 percent of 4/5 year olds in Luton are either overweight or obese. There are higher levels of deprivation in Luton than the national average (24.9 percent). 22.4 percent (10,800) of children in Luton are living in poverty (Public Health England, 2015). There is a clear link between high levels of deprivation and poorer health outcomes.

The Family Food First programme was based on a similar programme called the 'Healthy Under 5s Programme' which had been delivered across Bedfordshire and Luton by the Oral Health Promotion team of Community Dental Services and the Nutrition and Dietetic services of SEPT, Bedfordshire for 16 years. The Family Food First programme is based on a World Health Organisation Health Promoting Schools framework. This is a model based on the principles of the Ottawa Charter which promotes behaviour change through adopting agreed policies, engaging stakeholders within the setting, promoting a whole-setting approach and involving the community.

In order to achieve the aims of the project we needed to plan well from the beginning. We developed a logic model which has evolved overtime and will still continue to be adapted as we progress forward with programme evaluation. We have performance indicators which help us to track how the programme is progressing. These are only markers of activity, but they are still useful for mapping progress and inform the wider evaluation of the programme.

As part of our baseline data we ask that all staff in the early years setting and a minimum of 10 parents per setting complete a knowledge (and confidence for staff) survey.

Within the programme staff are required to attend training on nutrition, oral health and physical activity. Since the Family Food First programme started in 2014 we have changed the way we deliver the training and now ask for at least 50 percent of staff to attend training, before it was one member. In addition, we now deliver the training in-house to increase flexibility to settings.

The Family Food First programme is a small public health team within a larger community dietetic department based in South Bedfordshire, Dunstable, working for South Essex Partnership Trust, commissioned by Luton Borough Council. We work with other public health providers within Luton, calling upon their expertise to improve the work we currently do, i.e. Community Dental Services and Active Luton who provide us with specialist support in those areas, along with other key partners in early years education and health.

Aims and Objective

Aim: to encourage families with young children in Luton to adopt healthier lifestyles in order to reduce the burden of diseases such as obesity and tooth decay.

How: We work with early years settings, including nurseries, pre-schools and children's centres and support them to promote healthy messages to families.

Method and approach

We currently have 33 settings working towards accreditation.

For early years settings to achieve the family food first programme status they go through an accreditation process. This involves our team carrying out an initial audit on the setting and usually involves two members of our team observing a meal time (if cook on site we analyse menus provided), physical activity session and meeting with the appointed family food first coordinator and/or manager. An action plan is set and the setting is given a timeframe to achieve any necessary changes required. Training takes place within this time. This process usually takes between 6-12 months. Following this a follow up audit is carried out and if the setting is successful they achieve accreditation.

We have learnt that it can be difficult to obtain all the necessary evidence that is required from a setting. As part of the accreditation process settings are asked to provide evidence on their physical activity plans, menus, policies and activities that are carried out with an emphasis on healthy living with parental feedback on those sessions. Therefore we have had to adapt the way we request these depending on how the setting function, in some cases we have visited the setting again to receive these.

As we have only recently changed the way we train settings as mentioned previously it will be interesting to see whether this has more of an impact on staff knowledge (initial findings from surveys suggests that we are not meeting our target for change in knowledge before and after accreditation). Now more staff are being trained we would hope to see us meeting our target for this.

It has been challenging to use the data collected from staff and parents surveys to assess whether there has been a significant change. We have been looking at ways to improve what we currently do by linking up with other professionals, such as the research team at the local university, allowing for public health student dietetic placements to assist with the delivery and data collection of the programme and attending IT training to up skill within our own team. In addition, we have been investigating whether there are any validated tools of a similar nature which we could use.

Results and evaluation

As mentioned above it has been challenging to use the data collected from staff and parents surveys to assess whether there has been a significant change in knowledge and confidence. We have been looking at ways to improve what we currently do by linking up with other professionals, such as the research team at the local university, having public health student dietetic placements to assist with the delivery and data collection of the programme and attending IT training to up skill within our own team. In addition, we have been investigating whether there are any validated tools of a similar nature which we could use.

We are also looking into carrying out face to face interviews at the beginning and end of the accreditation to build on the current evaluation methods we use.

From our current data analysis (based on four settings) 75 percent of staff have good knowledge of healthy lifestyle behaviours (our target is 80 percent) and 55 percent are confident in supporting families with making healthy lifestyle changes (our target is 80 percent).

Key learning points

Be flexible, settings are generally very busy places, and they often have lots of other things going on. In order to increase participation you have to be as flexible and adaptable as possible.

We are aware that many of our settings are term time only therefore we have to ensure we plan around this.

Plans for Spread

In April 2015 the Family Food First programme was awarded the 'Advancing Healthcare Award' Sponsored by Public Health England for 'Contributions to Public Health'.

Our public team are part of the Children and Young People's Nutrition Network which allows us to share our work with others in the London area who are doing similar pieces of work. We continually share our work by updating our website and have recently joined Twitter to share what we do with the wider community. In addition, we plan to share our work with Fab NHS Stuff and within the trust itself.

Key Contacts

Lisa De'Ath, Public Health Dietitian, South Essex Partnership NHS Trust.
Find out more: www.sept.nhs.uk/familyfoodfirst

Case Study 13:
Multidisciplinary weight management service.

http://www.csp.org.uk/frontline/article/size-matters

Case Study 14:
Physiotherapists are uniquely positioned to facilitate physical activity required for weight management.

http://www.csp.org.uk/publications/physiotherapy-works-obesity

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Case Study 15:
The implementation of a Health Coaching training programme for clinicians working across the acute and community sector.

Understanding the problem

The challenges facing the NHS include flat budgets, a growing, ageing population, in addition to the increasing challenge of obesity, dementia and multi-morbidity (Simon Stevens, NHS Confederation, 2014). The number of people living with more than three long term conditions is set to rise by 1 million to 2.9 million by 2018 (Health Education East of England (HEEoE). People living with long term conditions (LTC) are more likely to use health and care services with patients

with LTCs accounting for 50 percent of all GP appointments, 64 percent of all hospital outpatient appointments, 70 percent of all hospital bed days and 70 percent of total health and social care spend (NHS England).

"Health Coaching is talking to people with (LTCs) in a way that supports and empowers them to better manage their own care, fulfil their self-identified health goals and improve their quality of life". Health Coaching describes many different interventions that coach or actively support people to selfcare and move away from a dependent model to one that is empowering and shared, based around a person's own aspirations and goals (HEEoE).

Health Coaching differs from traditional approaches to behaviour change. Traditional approaches tend to direct information "at" people and ask people to do the things that health professionals instruct them to do. In this traditional model, professionals are seen as having expert knowledge and are tasked with imparting this to people and their families. In contrast health coaching strives to help people and professionals to work in partnership. People themselves are seen as having important knowledge and as being experts in their own wellbeing.

Aims and Objective

Two senior physiotherapists from West Suffolk NHS Foundation Trust (WSFT) qualified as health coaching trainers in 2014 funded by HEEoE and trained by The Performance Coach. Their proposal was to roll out this pioneering two days health coaching training to multidisciplinary clinical staff at WSFT. The target was to train 200 clinicians in the first year with a view to embedding this training across the organisation in future years. Clinicians would learn a combination of tools and techniques they could use every day with patients that support behaviour change, help build rapport, improve listening skills as well as challenge patients more skilfully.

Method and approach

The delivery of Health Coaching training within WSH commenced following approval by the trust board in April 2015. This involved marketing, course administration, delivery, management, evaluation, CPD provision and on-going programme development.

Challenges included preparing a business case and having it approved by the trust executive group. In addition the roll out of the HC training programme coincided with the launch of the trust's electronic records system resulting in a lack of availability of training venues and a training embargo for a significant period of time during this first year of roll out.

Results and evaluation

Evaluation occurs immediately post-training and 6 weeks later at a continued professional development follow-up workshop. The feedback received has been consistently positive.

Currently there are 170 clinicians who have attended the two day programme (including 30 trained as part of the HEEoE project).

- 98% of those trained likely to recommend training to others.

- 96% report a strong or very strong mind-set shift.

- 100% agree or strongly agree that coaching is helpful for patients working with long term conditions.

- 99% agree or strongly agree that health coaching encourages greater responsibility and self-management.

- 100% agree or strongly agree that HCPs would benefit from learning something about using coaching with patients.

The stories clinicians have about how they have used Health Coaching in their everyday work are some of the most powerful ways of relating its impact. Two of these are summarised below:

"A patient with heart failure attended cardiac rehabilitation. At assessment he made a brief reference to his weight. I identified this and initiated a health coaching conversation with his consent. He went on to identify his barriers to controlling his weight, the triggers to falling into poor health behaviours. He came up with his own goal to lose one stone by the end of the 6 week programme and a further 1-2 stone in the following 12 weeks. On his 6th week at cardiac rehabilitation on weighing him he had lost a stone. He left feeling very positive and highly motivated to continue losing weight."

"A 40 year old patient with 7 year history of low back pain. He had had 2 failed spinal surgeries, previous physiotherapy intervention including a back pain management programme and had been through pain clinic. Despite this he felt disabled by his pain and hopeless about the future. He agreed to try Health Coaching where we talked about how he felt about key areas that are known to be important when self-managing a long term condition. At his 6 week follow up appointment he reported huge changes; he had been exercising every day, he had reduced his analgesia by a third, he had made contact with the community mental health service to address his low mood and was able to pick up his 2 year old child - something that he had previously lacked confidence to do."

Key learning points

- Write a business case up front and ensure it aligns with local strategy.
- Engage with local commissioners.
- Utilise local training teams.
- Secure administrative support early on.
- Top down support is invaluable.

Plans for Spread

Nationally Dr Penny Newman, Medical Director NCH&C and co-founder of the Health Education East of England Health Coaching Skills Development Programme was awarded an NHS England Innovation Accelerator (NIA) Fellowship for her work on this project. In July 2015 Health Coaching was selected as one of 17 innovations to receive an NHS England NIA fellowship. This NIA programme aims to deliver on the commitment detailed within the Five Year Forward View. WSFT has been recognized for its success in the implementation of Health Coaching training and the two WSFT Health Coaching trainers have been involved in the development of this NHS Innovation work nationally. On a local level the aim is to embed health coaching in the trust strategy and culture.

Key Contacts

Trudi Dunn and Nina Finlay, Clinical Specialist Physiotherapists, West Suffolk NHS Foundation Trust. Email: healthcoaching@wsh.nhs.uk

Case Study 16:
Good Lives.

Understanding the problem

There are increased demands on local government and health services driven by central government, efficiency targets and rising user expectations. This is alongside increased budgetary pressures due to the increase in minimum wage and the current market for care and support services which are in high demand, in some cases exceeding capacity. The need for change is a priority across government and health sectors with a need to address the cultural change necessary to create more outcome-focused and less activity-focused organisations.

Aims and Objective

In August 2015 Essex County Council and the local clinical commissioning group (CCG) came together to develop initiatives under the 'Good Lives' programme. This commenced with a pilot site which developed a multidisciplinary approach involving multiple agencies and sectors, all working for the benefit of patients at a GP practice in Colchester. The programme was led by primary care but sought to challenge and change the way services are currently provided. The focus was on prevention and independence for a cohort of patients living in the community who were on the GP admission avoidance list. All had long term health conditions and the majority were older people. The pilot aimed to achieve the following objectives.

- Reduce hospital admissions.
- Reduce formal (often long term) health or social care services.
- Develop multidisciplinary team working.
- Connect non-statutory support as early as possible to contribute to self-help.

This approach combined primary health, voluntary organisations and social care professionals, aiming to play to the strengths of each while feeling like a single service from a patient perspective. A collaborative way of working was established, based around the GP's admission avoidance list, and at its heart an emerging multi-speciality community provider and primary and acute care system models. In addition, using local community, charity and voluntary sector through "social prescribing" as a way of linking people to activities in the community and connecting people to non-medical sources of support.

Method and approach

Partners for Change (P4C) worked in collaboration with Essex County Council and the CCG to co-design and develop this approach locally. It is based on a previous model of delivering Adult social care that P4C developed through working with a number of councils. The 'Good Lives' approach is based on P4C's model which identifies three areas that matter to older people.

- Independence - being able to do activities that are important to them.
- Community interactions - having control over the social contact they had.
- Decision making - having choice and control over the important decisions in their life.

The Good Lives approach has three "real" conversations with people at different levels. Each level is applied using a specific set of rules and replaces the traditional 'contact then assessment for services' approach.

Level 1 - This is about keeping the person able, independent, active and self-managing. A strong focus is on people's own assets, strengths, on the local community resources and networks and what it can offer to maintain a healthy life rather than formal health and social care assistance.

Outcome: To get people connected so that they can continue to live independent inclusive lives.

Level 2 - This conversation focusses precisely on what needs to change, and how the professional can support the necessary changes. Again the focus is not on formal health or care services, but whatever will help make the needed change happen. At this level, the person may only need assistance in managing a newly diagnosed condition or learn about how they can support themselves again with a focus on community resources or it could include reablement, a home care package, regular district nursing support or intermediate care.

Outcome: To regain independence and control.

Level 3 - The aim of conversation three is to design support, ideally using a personal budget, to enable them to live life, according to the wishes and hopes of the person. Included in these discussions could be around their preference for end of life care. Support would be provided to people to ensure they have control about their preferred place and time of support and using community and including natural support. Outcomes from Level 1 and 2 need to be incorporated into level 3 conversations.

Outcome: In control of your life.

Results and evaluation

Feedback from patients indicates they had greater confidence and felt more able to manage their own health and care needs. This has meant they have been able to live more independently at home and within their communities. For family members and carers this also had a positive outcome as they felt assured that their family member had increased choice and control over their lives.

Trust and greater partnership developed across partners which resulted in improved customer journeys for people. For example, the patient was not aware that they were dealing with multiple agencies and they had only to tell their story once. This was achieved by working jointly to develop a greater understanding of each other's roles.

The Good Lives approach ensured staff were Care Act compliant particularly when working with carers. A significant number of carers in addition to the original cohort were supported to be able to continue with their caring role through the Good Lives conversations.

The most significant benefit and potential cost saving is the reduced need for multiple assessments. Although hard to define, there is transactional cost reductions associated with improved multidisciplinary and organisational working. The proactive approach resulted in improved outcomes through a shorter customer journey.

Benefits for Health systems occurred as a result of preventing or delaying emergency admission or attendance at GP has reduced pressure on these systems. In many of the cases there was recognition that the approach resulted in a lowering of the likelihood that the person would require hospital admission and in some cases where the carer was under pressure there was a reduction in admissions to residential care The financial modelling of this is not always possible and further work on this would be required with health and social care colleagues.

There are also benefits to inward investment into the local economy due to attracting external funding into the wider economy through increased uptake in benefits and other financial entitlements as the conversation approach included considering each individual's financial position.

Key learning points

Buy in is required across all parts of the health and social care systems. There is no point in adopting the approach unilaterally.

Start small and think big was a key learning point.

Plans for Spread

The approach is now widely adopted across Essex County Council and further engagement with partner organisation including community matrons, fire service (community builders), primary health services, voluntary organisations and housing sectors. It has been agreed as an approach by the CCG.

Key Contacts

Rachel Richardson-Wright, Service Manager, Essex County Council.
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Case Study 17:
Primary care MSK first contact practitioner.

Understanding the problem

The aim of this project was to pilot whether an extended scope MSK Physiotherapist working in a GP practice as a first contact practitioner could impact on the patient pathway and potentially impact on GP capacity. GPs are under significant pressure for appointments, bringing specialist knowledge to the first point of contact may improve the pathway and experience for patients. It was proposed that if in place less face to face contacts would be needed, quicker access to care would occur and potentially fewer prescriptions utilised. The extended MSK role allows the clinician to make radiological referrals, provide injection therapies and also refer directly into secondary care.

Aims and Objective

To identify the potential for first contact physiotherapists to be working in GP practices without the need for GP referrals offering radiological referrals, injection therapies, advice and guidance and referral into specialist services.

Method and approach

This project is part of a vanguard pilot and collaborated with a local GP practice; it has now expanded into other practices and also as part of a primary care access centre providing first contact work.

Results and evaluation

The data so far has shown that an MSK physiotherapists manages 64% patients with advice and guidance, refers less than 20% of patients for physiotherapy as compared to a GP practice (30%), has significantly less prescription requests made (8% compared to 40%), provides quicker access for diagnostics and direct surgical referrals with full diagnostic work up prior to referral (such as MRI). Patient satisfaction is high (100%) noted in an early audit with some associated qualitative data highlighting the benefits of a "complete" MSK assessment.

Key learning points

Patient satisfaction was high. GPs are more likely to prescribe medication. Radiological referral percentages were similar and yet MSK clinician has MRI access, so this would suggest greater effectiveness. MSK clinicians had less follow up appointments.

Plans for Spread

The model is being rolled out to 11 clinics in the locality.

Key Contacts

Neil Langridge, Consultant Physiotherapist, Southern Health NHS Foundation Trust.
Email: neil.langridge@southernhealth.nhs.uk

Case Study 18:
Improving evidence-based management of irritable bowel syndrome across Somerset.

https://www.nice.org.uk/sharedlearning/improving-evidence-based-management-of-irritable-bowel-syndrome-across-somerset

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Case Study 19:
Direct Access Physiotherapy Service.

https://casestudies.csp.org.uk/case-studies/physiotherapy-first-direct-access-physiotherapy-service

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Case Study 20:
Service providing genuine 'first point of contact' care for patients with MSK related conditions, as an alternative to GP care.

Understanding the problem

Nottingham CityCare is a CIC social enterprise providing care for predominantly NHS contracts in Nottingham City. This is a primary care setting and relates specifically to general practice. This project relates to the musculoskeletal (MSK) clinics team which comprises physiotherapists and occupational therapists.

MSK related health complaints provide a large, growing and predicted to grow further, population of patients. Patients with MSK related health complaints are estimated to make up 30 percent of a GP caseload. There are also acknowledged increasing demands faced by the general practice, medical, workforce in terms of training, recruitment and retention. If some of the clinical demand could be alleviated by the provision of first point of contact - or self-referral - physiotherapy for this population of patients the overall burden on GPs could be reduced. This could have significant implications for the sustainability of general practice, in primary care.

Aims and Objective

The aim of this project was to evaluate a one-year pilot of provision of the '1st Line Physiotherapy service. This provided first point of contact physiotherapy in two GP practices for one year with patients offered the opportunity to see a physiotherapist, if they were experiencing a MSK related health complaint, as an alternative to a GP appointment. The aims were to:

1. Evaluate the clinical efficacy of the 1st Line Physiotherapy service.

2. Evaluate the patient satisfaction with the service.

3. Undertake an 'average cost per episode of care' evaluation of the service and compare this to a retrospective cohort of patients who received GP care/management.

Method and approach

The project ran from April 2014 to March 2015. Two MSK physiotherapists (band 7) were introduced as first contact MSK practitioners to provide two half-day sessions per week in the inner city and university GP practices in Nottingham for a year. Within the service patients were assessed and offered advice, exercise, prescription or referral onwards, as appropriate. The proposal was presented to the CCG who supported the project.

Several outcomes were collected:

* health status (EQ-5D)

* change in complaint (Global Rating of Change)

* patient satisfaction

* resource utilisation

The clinical service made the initial proposal internally supported by the therapy services manager and subsequently the CityCare senior management team. The proposal was then put to the CCG with clear objectives and outcomes detailed.

Critical in the delivery of the project was the strong clinical and team leadership, and the relationship between provider and commissioner. The level of support internally, from commissioner and subsequently the practice manager buy-in was essential in getting the service up and running.

The project was implemented within four months of conception and agreement. All patients who called to make an appointment were offered the option of seeing the physiotherapist, as an alternative to the GP, if they had an MSK problem. The service was limited to two half-hour sessions. If ongoing physiotherapy was needed patients were referred onwards to the community MSK physiotherapy service.

There was a risk of a limited service capacity, creating long waits for patients and communication difficulties within the GP practices involved. This was mitigated by placing a maximum allowable wait for patients referred to the service, with GP care being the fall back, and sharing electronic record systems for clear communication.

Results and evaluation

The 1st Line Physiotherapy Service, delivered at an Inner City practice (ICP) and the University practice (UP), proved safe, effective and efficient. The service was delivered by band 7 MSK physiotherapists in two half-day sessions per week. Two clinical outcome measures were used: The EQ-5D-5L descriptive system and the Global Rating of Change (GROC) questionnaire, with measurements taken at assessment and at six months. Improvements were demonstrated in clinical recovery, with 41% of ICP and 68% of UP patients being discharged to self-manage after the initial visit. 350 patients returned patient satisfaction surveys and overall reported great confidence in the physiotherapists' ability to assess and treat them.

Overall, the service achieved the following:

- The number of patients managed by the MSK service and discharged increased.
- Follow-up appointments and investigations reduced, delivering a cost saving.
- Improvements were found in patients' clinical recovery, with over 70% reporting continued improvement at six months.
- Patients reported satisfaction and confidence with the service provided by the physiotherapists (87% ICP and 73% UP) satisfaction in information provision and confidence in the practitioner.
- Patients improved in their health status over six months.
- The physiotherapy service was considerably more cost effective.

The MSK Pilot results for the two practices: April 2014 - March 2015

- 555 patients were seen; n=219 ICP and n=336 UP.
- 71% (n=393) successfully managed by the MSK service (63%; n=138 ICP and 76%; n=255 UP).
- 27% (n=152) referred into secondary care MSK Physiotherapy (35%; n=78 ICP and 22%; n=74 UP)
- 6% (n=6) referred into secondary care: Orthopaedics (1%; n=3 ICP and <1%; n=3 UP).
- <2% (n=9) referred back to their GP (<2%; n=4 ICP and <2%; n=5 UP).
- Patient satisfaction questionnaires reported satisfaction and confidence with the service provided by the physiotherapists and an improvement in their health status.
- 3% (n=15) of cases necessitated extended skills in requesting diagnostics (5%; n=11 ICP and 1%; n=4 UP)

Cost and Savings

The physiotherapy service was considerably more cost effective, averaging £56.51 and £84.26 per patient at the Inner City and university sites compared with GP costs of £366.44 and £647.16 at the same practices.

Average number of appointments per patient	ICP	UP
GP	2.22	1.66
MSK Physiotherapy	1.22	1.09

A comparison of referrals to secondary care (orthopaedic referrals) of the GPs pre-introduction of the MSK service (Jan - Dec 2013) and the service in its first year showed a significant reduction in referral rates.

Referral to orthopaedic secondary care	ICP	UP
GP	16%	8%
MSK Physiotherapy	1%	1%

Nottingham CCG provides data to support calculation of the average cost for a secondary care referral to trauma and orthopaedics as £3,085 per patient, indicating a significant saving through the use of the MSK physiotherapy service.

The full published report on this service can be accessed via:

https://www.researchgate.net/publication/303826910_Physiotherapy_as_a_first_point_of_contact_in_general_practice_a_solution_to_a_growing_problem

Key learning points

The pilot proved efficacious both from a safety perspective, a patient satisfaction perspective and from a clinical outcome perspective. Also, there are economic benefits. The implementation requires strong leadership, provider management and ideally an effective provider-commissioner relationship.

Plans for Spread

The project has been disseminated as widely as possible:

- The local CCG received the report.
- The author has presented locally and nationally with a publication, as above, and presentation at the Royal College of General Practitioners Annual Conference, 2016.
- The Chartered Society of Physiotherapy has included the project in their case studies report/database.

Key Contacts

Rob Goodwin, Clinical Lead Physiotherapist and PhD candidate, Nottingham CityCare CIC and Nottingham University. Email: msxrg6@nottingham.ac.uk

Case Study 21:
Physiotherapy - changing the face of primary care.

Understanding the problem

AHP Suffolk is a social enterprise serving the people of Suffolk and surrounding areas. We pride ourselves in delivering a high quality, responsive, and patient-focused service. We are commissioned to provide physiotherapy to Suffolk, management consultancy in Norfolk and online web triage to North Essex and Norfolk. Our CCG wanted us to reduce physiotherapy wait time, reduce secondary care referrals and provide a single point of access service. Since this has been addressed the changes are saving the NHS money, driving down secondary care referrals, freeing up GP time and most importantly achieving high patient satisfaction with extremely low wait times and getting people to the right place at the right time. This has been sustainable for the last five years.

Aims and Objective

- Reduce physiotherapy wait time.
- Reduce secondary care referrals.
- Provide a single point of access service.

Method and approach

Reducing waiting times

We developed our unique online self-referral portal. Patients can self-refer or be GP directed via our website and filling in all the required information or via telephone where one of our admin team will fill the information in for them. They will be trained and sent advice and exercises by email or post within 24 hours of submitting their referral. This leads to a 20% attrition rate, with patients seemingly happy with the advice, and saves 0.8 of a follow up appointment when they do go through to face to face physiotherapy. All stakeholders are benefitted and there have been no adverse incidents. We have also not found any overall increase in referrals in the seven years it has been running.

Reducing secondary care referrals

We put in a number of different pathways. Our most successful being our hip and knee pathways which we developed in collaboration with our CCG due to high rates of arthroplasty in the area. The pathways which consist of a series of education and exercise sessions with telephone follow up reduced the need for arthroplasty by 20% in the area.

Provide a single point of access

Again with the focus of bringing secondary care referrals down, a paper exercise increasing the points of contact didn't seem efficient to us, so instead we ran a trial in collaboration with the CCG to place physiotherapists in GP surgeries as direct access, seeing the musculoskeletal case load that comes through the door. This trial is ongoing and going very well. We are achieving high patient satisfactions on friends and family scores and the patient satisfaction questionnaire, freeing up GP time and reducing secondary care referrals. In the two GP practices, over the first 6 weeks our physics made two secondary care referrals, compared to a combined 48 during that period last year.

We are also acutely aware of the rising decline in health across our population and the need for a focus on self-management so we run a 'walk with a physio', an 'open gym' for patients and are in the process of developing a new self-help website and an exercise app.

Results and evaluation

Reducing waiting times

The online self-referral portal has led to a 20% attrition rate, with patients happy with the advice, and saves 0.8 of a follow up appointment when they do go through to face to face physiotherapy. All stakeholders are benefitted and there have been no adverse incidents. We have also not found any overall increase in referrals in the 7 years it has been running.

Reducing secondary care referrals

The change in pathways, which consist of a series of education and exercise sessions with telephone follow up, reduced the need for arthroplasty by 20% in the area.

Provide a single point of access

This trial is ongoing and going very well. We are achieving high patient satisfactions on friends and family scores and the patient satisfaction questionnaire, freeing up GP time and reducing secondary care referrals; in the two GP practices, over the first 6 weeks our physiotherapists made 2 secondary care referrals, compared to a combined 48 during that period last year.

Key learning points

GP education has been key to success.

Plans for Spread

The online portal has been shortlisted for an award at the O2 digital awards.

The service is also running in Norfolk and Essex which is proving successful. And, Norfolk has contracted the service to do a whole management insertion from diary planning, pathways and single point of access.

The team has presented at the UK Health Show and Commissioning Live and has interest from all over the country.

The hip and knee pathways won clinical team of the year award and the General Practice Awards.

Direct access / first point of contact practitioner service - the CCG are already looking at rolling it out in all GP practices.

Key Contacts

Jo Keller, Operations Director. Email: joanne.keller@ahpsuffolk-cic.nhs.uk

Bradley Scanes, Clinical and Service Development Lead, AHP Suffolk.
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Case Study 22:
Community paramedics charged with keeping people out of hospital.

https://www.theguardian.com/society/2016/jan/20/the-new-breed-of-paramedics-charged-with-keeping-people-out-of-hospital

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Case Study 23:
A physiotherapy-led Virtual Clinic for the Orthopaedic Fracture Clinic.

https://casestudies.csp.org.uk/case-studies/physiotherapy-led-virtual-clinic-orthopaedic-fracture-clinic

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Case Study 24:
Dysphagia management improves quality of life and reduces medical complications and death.

Understanding the problem

Eating, drinking and swallowing difficulties have potentially life-threatening consequences. They can result in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. They can also make taking medication more difficult. Swallowing difficulties can result in avoidable hospital admission and in some cases death. They can also lead to a poorer quality of life for the individual and their family. This may be due to embarrassment and lack of enjoyment of food, which can have profound social consequences.

Dysphagia often forms part of other health conditions for which a person is being treated so it is difficult to be certain of the prevalence rate. However, research has found the following rates of prevalence and incidence:

- Between 50-75% of nursing home residents.

- Between 50-60% of head and neck cancer survivors.

- Between 40-78% of stroke survivors - of those with initial dysphagia following stroke, 76% will remain with a moderate to severe dysphagia and 15% with profound dysphagia.

- In 48% of patients undergoing cervical discectomy and fusion.

- In 33% of the people with multiple sclerosis.

- In 27% of those with chronic obstructive pulmonary disease.

- In 10% of acutely hospitalised older people.

- In 5% of adults with a learning disability, 5% of community-based individuals with learning disabilities and 36% of hospital-based individuals.

Aims and Objective

Speech and language therapists (SLTs) play an important role in supporting adults who have eating, drinking and swallowing difficulties (dysphagia) to eat and drink safely. They do this by working directly with individuals or indirectly by training others, including families and the wider health and care workforce, to identify and manage problems.

Method and approach

Speech and language therapists have a unique role in the assessment, diagnosis and management of swallowing difficulties. They:

- play a key role in the diagnosis of dysphagia

- help people regain their swallowing through exercises, techniques and positioning

- promote patient safety through modifying the texture of food and fluids, reducing the risk of malnutrition, dehydration and choking

- promote quality of life, taking into account an individual's and their families' preferences and beliefs, and helping them adjust to living with swallowing difficulties

- work with other healthcare staff, particularly dietitians, to optimise nutrition and hydration

- educate and train others in identifying, assessing and managing dysphagia, including families and the wider health and care workforce.

Results and evaluation

Early identification and management of dysphagia by speech and language therapists improves quality of life, and reduces the possibility of further medical complications and death. Improved nutrition and hydration have an impact on physical and mental wellbeing. In addition, speech and language therapy for those with dysphagia also produces economic benefits and savings for the wider health economy, including through avoided hospital admissions.

Economic impact research showed that every £1 invested in low intensity speech and language therapy for adult stroke survivors with swallowing problems generates £2.30 in healthcare savings through avoided cases of chest infections.

15% of hospital admissions of people with dementia with dysphagia could be prevented by contributions from a speech and language therapist at an earlier point.

Key Contacts

Royal College of Speech and Language Therapists. Email: info@rcslt.org

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Case Study 25:
Service Redesign: Integration of adult community occupational therapy and physiotherapy.

Understanding the problem
- To set the scene at the start of our journey to integration there were separate occupational therapy and physiotherapy teams, variation in therapy provision across community teams, services provided in professional silos, demand outstripping capacity evidenced by waiting lists and no progressive funding over several years to community services.
- Other drivers: five year plan, ageing population, local commissioner's vision for integrated service over seven day working.
- A key driver financially was the reconfiguration and delivery of intermediate care across the health economy specifically reablement with therapy. The finances accompanying this change in service delivery provided the opportunity to fund recruitment to kick start the process of integration.
- Workforce analysis identified the need to increase baseline capacity, reduce duplication and improve the ability of staff to work across professions to best meet patients' needs.

Aims and Objective
To become a Community Integrated therapy service, demonstrating effective multidisciplinary working, across five localities, over a seven day working week.

Method and approach
The process of integration started in November 2011 with a business case for reablement funding to facilitate the expansion in reablement service in social care. This enabled intensive recruitment of qualified, non-qualified, and administration staff to enable service redesign following the footprint of five localities.

The development of new roles supported the integration process and was the foundation for skill sharing:

- Assistant practitioners (band 4) working across physiotherapy, occupational therapy, speech and language therapy and dietetics;
- Integrated therapy technicians (band 3) working across physiotherapy and occupational therapy

Development of new processes and systems underpinned the process:

- Integrated referral, integrated triage, triage matrix, joint documentation, integrated outcome measures and reallocation of administration resources to increase productivity and case load weighting.

An integrated approach to skills training encouraged shared learning and skill sharing examples included resilience training, triage skills and aids and adaptations.

In 2015 extended hours and weekend working was implemented. Staff engagement was achieved through away days and local team development through staff meetings.

Barriers to integration: Co-location was hampered by estates. Development of initiatives takes time to embed to ensure staff felt confident. Initial evaluation and outcome tools required modification.

Results and evaluation

Evaluation included data collection on impact recording sheets, patient stories, clinical outcome measures, staff evaluation and internal review of extended hours /weekend working after 12 months.

Key learning points

- Strong leadership at all levels to guide and support staff.
- Foster positive attitude to change.
- Empower and engage the whole staff group to make changes.
- Co-location is fundamental to success.
- Continually acknowledge staff success.
- Allow time to embed service development.
- Respond to evaluations and readiness to change direction as a result of evaluation.

Plans for Spread

Currently supporting acute occupational therapy and physiotherapy services within East Lancashire Hospital Trust in the process of integration.

Key Contacts

Gill Dawes, Community Integrated Therapy Team Leader. Email: Gillian.dawes@elht.nhs.uk

Catherine Ashworth, Clinical Co-ordinator for Pendle Integrated Neighbourhood Team. Email: Catherine.ashworth@elht.nhs.uk

Case Study 26:
Integrated Care Services (iCares). Transforming and Integrating Community Services within admission avoidance, care management and community rehabilitation services.

Understanding the problem

We faced a perfect storm in 2012:

- Increasing demand with patients who were increasing complex.
- Long waits for routine appointments (40+ days).
- Most services five days.
- Part time admin staff and answer machines.
- 6% cost saving target.
- Commissioners wanted something different including more responsive services.
- Users wanted less complexity and one point of access.
- Paper heavy processes.
- Low staff morale.

Aims and Objective

We used the opportunity of a Department of Health project to apply the evidence base for long term conditions management to our problem. The three main themes of this are;

1. Integrated locality teams.
2. Risk stratification of population.
3. Systematic implementation of selfcare and self-management .

Our aims and objectives were:

Patients with long term conditions and/or neurological impairment rarely present with one aetiology and often require the intervention of both health and social care, particularly during a period of crisis or deterioration.

Redesign assumptions

- Senior decision makers early in process result in a more timely assessment, tighter care planning and less time spent in statutory services.
- Service users and commissioners want to use a single point of access.
- Services should be responsive irrespective of setting or aetiology.
- Processes and systems should be lean across organisational boundaries, reducing duplication and providing efficiency.
- Integration of services to meet QIPP agenda for LTC and deliver the best high quality care.
- Selfcare and self management should be embedded into every contact and care plan.

Aims

1. Further deliver the care management specification.
2. Deliver QIPP LTC agenda of integrated teams around a locality.
3. Meet increasing demands and increasing complexity of care.
4. Make cost savings.
5. Ensure CCGs receive a service they will commission into the future.
6. Be a provider of choice.
7. Clear leadership for pathways > locations.
8. Develop care for the next five years.

Future state

- Current teams will be integrated.
- Referrals will be received and triaged irrespective of aetiology.
- The clinical decision making at triage will aim to match clinical need to clinical competence ensuring a timely service with senior decision making early.
- Referrals will be categorised as unknown, unpredictable and predictable.
- No clients will stay in the service for life; repeated access to meet needs will be the norm as condition changes.
- Self management and reablement episodes of care are core to service delivery.

Method and approach

As a leadership team we identified a high level model to meet the future state vision. We used the Kotters change management model and embarked on a six month change programme. This included staff and stakeholder engagement via listening into action events, working parties and market place events.

A new standard operating procedure was written with the help of all staff. Understanding and supporting the culture and values of teams, learning styles and change were critical to the change process, with a heavy use of Fishers Change Curve. Leadership was critical to taking every on the journey.

The comms strategy was reviewed fortnightly and every method of communicating with people was employed - bulletins, newsletters, emails, open door, staff meetings, lunches. Formal management of change embedded changes to T&Cs including hours of work, line management structures and bases for working.

The new service was launched on 1 October 2013 and was only 80% "right". We have used a PDSA cycle since then to evolve and continuously improve what we do.

Evaluation has focused on:

- Response times
- User feedback
- Staff feedback
- Length of stay in service and community beds
- Referral management
- Readmissions

Results and evaluation

Main Results

- Single point of access and no answer machines.
- Open access for life.
- No referral forms.
- Very few criteria for access (any adult 16+ who needs admission avoidance, case management or community rehab irrespective of diagnosis or location).
- Triage at point of referral to determine users needs with the user.
- No waiting lists.
- Appointment given at point of triage matched to the most appropriate professionals (s) to meet their needs.
- Integrated locality teams delivering joined up care.
- Inter professional working and competences.
- Service now seven days a week.
- Urgent appointments within three hours, routine appointments within 15 days.
- Paper free.
- Leaders manage multi professional teams / no professional leads.

Impact - outcomes and benefit

- Its easy to navigate.
- Users love it and we are meeting their needs.
- Access via a single point and open access for life - no criteria, no barriers to getting in. As a patient or carer just give us a ring and you can come back at any time.
- Response times - urgent nurse/rehab appointments within three hours, seven days a week. Routine appointments within 15 days.
- Patient satisfaction - 98% of patients would recommend the service to their friends and family.
- Staff satisfaction - 88% of staff feel involved in decisions and changes.
- Outcomes - 90% of patient sets goals are achieved or part achieved.
- 93% of people stay in the community after an urgent visit rather than being admitted to hospital.

Any cost savings?

Annually between 6% - 3% mixture of pay and non-pay achieved through productivity and skill mixing.

Any increases in efficiency and productivity?

- Meeting increased demand, taking on new projects and contributing to research with some additional funding but not enough to account for total increased activity.
- 50% increase in admission avoidance activity.
- Contribution to 2% reduction in readmissions.
- New roles including assistant practitioners.

- New models of care:
  - Own Bed Instead - intensive rehabilitation / intermediate care at home for four weeks.
  - Bridging the Gap - Agewell CIC delivering rehab programmes and post NHS care so reducing length of stay in rehab unit and reducing readmission rates.
  - Care homes dysphagia champions - reducing referrals to speech therapy as care homes manage their own simple referrals.

Key learning points

- It's a journey.
- Always concentrate on culture and values.
- The power of patient stories to keep focussed.
- You are allowed to make mistakes.
- It doesn't have to be perfect.
- You can't communicate too much.
- Ask for help and don't reinvent the wheel.

Plans for Spread

Won Nursing Times Award for Integrated Care in 2014.

Cited in the following publications:

- Kings Fund (2014) Making our health and care services fit for an ageing population.
- NHS England (2016) Commissioning Guidance for Rehabilitation.
- Toby Lewis, CEO of SWBH described iCares as "an extraordinary testimony to inter-professional working" during a visit by Jim Mackey, CEO of NHS Improvement.

Key Contacts

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Case Study 27:
Early Intervention Team - Integrated working to reduce admissions and enable early supported discharge.

Understanding the problem

- Increasing Emergency Department (ED) attendances.
- Growing older population and number of patients with complex conditions (West Suffolk CCG).
- Growing evidence base highlight poor outcomes for older patients with long hospital stays.
- Early Intervention Team (EIT) (Occupational Therapy and Physiotherapy service) based in ED and Acute Medical Unit (AMU) weekdays only.
- Patients staying in hospital at weekends and evenings awaiting therapy and social care response.
- Consultants requesting EIT to work weekends and work later.
- Referrals by EIT on to social services and voluntary sector making processes slow and disjointed.
- Delays in care packages being able to commence.
- Initial trial of weekday extended hours and weekend working highlighted able to discharge patients but needed social care input and transport.

Aims and Objective

- Applied for funding from West Suffolk CCG to increase team size and become fully integrated.
- Integrated working between health, social care and voluntary sector.
- Aim to reduce conveyances to ED by moving resource to community.
- Provide a seven day extended hours service.
- Improve patient experience.
- Promote reablement (reduce waits for services).
- Cost avoidance for length of hospital stay.
- Improve long-term health.

Method and approach

Phase 1

- 8:30 - 9:00 weekdays and 10:00 - 5:00 weekends.
- Integrated wraparound service, integrated assessment:
  - Therapies (West Suffolk NHS Foundation Trust).
  - Age UK Suffolk (to take patients home, settle them and provide ongoing support).
  - Suffolk Social Services.
  - Dementia liaison nurse (Norfolk and Suffolk NHS Foundation Trust).
  - Carers through external agency.
  - Access to geriatricians.

Phase 2

- Extension of integrated enhanced team:
  - Colocation of community nurses (Suffolk Community Healthcare).
  - Carers brought in-house.
  - Suffolk Family Carers link worker.
- Referrals from Ambulance Service, social services, community health teams, hospice, housing associations.

Results and evaluation

- Improved communication, integrated team in same office "one-stop shop" holistic assessment.
- In ED seen as part of the core team, improved relationships and respect.
- AHPs empowered.
- Increased referrals to EIT in ED and increased discharges preventing unnecessary admissions.
- Reablement focus for care using AHPs and social workers to promote independence.

Challenges

- Difficulties with different organisations using different IT systems and systems not communicating. Governance agreements.
- Delays in handing over- care to social services (after five days under EIT).
- Do not have same agreements and efficiencies in place for out-of-county patients.
- Short term commissioning stifles innovation and recruitment.

Results

- December 2012- April 2013: **360** avoided admissions and early support discharges.
- December 2013- April 2014: **777** avoided admissions and early supported discharges.
- December 2014- April 2015: **971** avoided admissions and early supported discharges.
- December 2015- April 2016 **1559** patients seen in the community, **804** avoided admissions and early supported discharge. Conversion of ED attendance to community admission prevention.

Key learning points

- Team need to be involved in change and adapt to change.
- Need to manage expectations of what service can offer and public/ professionals need further education that hospital is not the location for addressing complex issues.
- Need to be able to demonstrate effectiveness and need to coordinate data from all partners of integrated team to justify service.
- Promotion to primary care takes time.
- AHPs have a key role in urgent care.
- Having access to rapid care is essential to an admission prevention service.

Plans for Spread

• 24 hour reablement support worker (carer) service to prevent admissions.

• Further integration with the Ambulance Service, GPs and 111.

Key Contacts

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Case Study 28:
Barnet Rapid Response Team.

Understanding the problem

Patients admitted to the Emergency Department or Adult Assessment Unit later in the day were at higher risk of admission to hospital because the rapid response team service finished at 5pm, with last referrals accepted at 4pm.

A pilot for an Extended Hours Therapy Service in A&E was agreed in 2014 to test whether extending this time by one hour would have a positive impact on admissions and be cost effective to the trust.

The Barnet Rapid Response Team provide a seven day service, with designated team leads in each area. The team consists of:

• Clinical Lead B8A Occupational Therapist.

• 3x B7 Occupational Therapists, 3x B6 Occupational Therapists.

• 3x B7 Physiotherapists, 2x B6 Physiotherapists, 1x B5 Physiotherapist.

• 1x B6 and 1x B4 Therapy Support Workers and 1x Administrator.

The team responsibilities include:

• Screening and prioritising in the Emergency Department, Adult Assessment Unit and the Medical Short Stay Unit.

• Initial, functional and cognitive, risk and falls assessments across Emergency and Acute Medicine as well as Outpatient Clinic such as Ambulatory Care and Fracture Clinic.

• Review of medical investigations and liaison with multidisciplinary team re: medical issues.

• Case management, discharge planning and facilitation.

Aims and Objective

To extend therapy cover by accepting referrals up until 5pm on weekdays to improve patient outcomes and reduce number of unnecessary admissions.

Method and approach

For six weeks the teams working hours were extended using a voluntary overtime scheme to increase capacity to accept referrals up until 5pm, explore the need and analyse the impact on patient admissions. To measure the impact, data was collected on referrals, number of admissions prevented, discharge destinations, hospital length of stay, and the length of the therapy input provided for each referral.

Results and evaluation

Total number of referrals = 13

Average success of discharge (%) = 69%

Average length of stay for patients not discharged = 8.3 days

The six week pilot demonstrated that although the referral rate to therapy was not high the team were able to discharge 69% of patients referred. Those patients either returned home or were offered rehabilitation or an admission avoidance community bed. Comparative to a small cost to provide a therapy service during the pilot, the data clearly demonstrated cost effectiveness in bed days saved and a positive outcome for patients returning home. It was agreed that extended hours was to remain.

Subsequently the Rapid Response Therapy team implemented extended hours from January 2015 and figures have revealed a continual improvement in preventing admissions as the service has embedded within the Emergency Department.

Current Extended Hour Data (2016)

Average number of referrals per month = 14

Average success of discharge (%) = 80%

Average number of discharged patients per month = 11

Average therapy time for each referral = 138 minutes

- The admission length of stay (LOS) for a sample of patients that were not able to be discharged was tracked at 7-11 days (Median LOS = 9).

- The national average for a non-elective inpatient stay (long stays) is £2,863. (PRSSU 2015).

- Multiply this by the 11 patients discharged by therapists working extended hours; the cost would be £ 31,493 per month to the trust if those patients were not discharged.

- On this basis if these 11 patients per month were admitted it would cost +/- £377,916 per year.

- Average cost per month to have 2 WTE therapists provide an overtime service to accept referrals until 5pm is £492 per month and £5,910 annually.

(Personal Social Services Research Unit, 2015. Unit Costs of Health and Social Care 2015.
Available at: http://www.pssru.ac.uk/project-pages/unit-costs/2015/index.php)

Key learning points

Following a short pilot in 2014, the cost effectiveness of providing an extended therapy service in the Emergency Department and Adult Assessment Unit was conclusive in preventing hospital admissions and improving patient outcomes. This service has been embedded since January 2015 and on-going data collection continues to prove the benefit of therapists working on the front line.

Plans for Spread

Shared with the College of Occupational Therapists for Occupational Therapy: Improving Lives, Saving Money Campaign.

Key Contacts

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Case Study 29:
A physiotherapist and a paramedic join forces - responding to emergency calls that are not life-threatening.

http://www.csp.org.uk/news/2015/10/12/physio-paramedic-pool-resources-lakes-initiative

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Case Study 30:
Occupational Therapy led service in the Emergency Department (ED) preventing hospital admission and/or effecting early discharge.

Understanding the problem

Central London Hospital and Major Trauma Centre ED Occupational Therapy (OT) service is an extremely mature service (Est, 1992), that commenced in response to the increasing number of patients requiring specialist therapy services to support early and timely discharges, thereby preventing unnecessary hospital stays or admission.

Uniquely this service is OT led. OT were preferred based on the consideration of best value for money skills for the client group referred, using strengths in problem solving, applying retraining and/ or compensatory strategies for activities of daily living (ADL), while appreciating the cognitive and psychosocial factors. These skills would be naturally supplemented by up-skilling to conduct mobility assessments, provide mobility aids, broker emergency care packages/placement and placing onward community service referrals for follow up.

Aims and Objective

To offer traditional OT and extended scope interventions to facilitate early discharge home from ED or Clinical Decisions Unit (CDU) , the ED observation ward.

Method and approach

An OT led, seven day shift service which has an office on the Emergency Department and Acute Admissions wards. The team offer:

- Upper limb fracture care, management and ADL retraining.
- Lower limb fracture / injury management, mobility aid provision and ADL retraining.
- back and rib injury management, ADL retraining and advice.
- Commence therapy interventions for trauma and "silver trauma".
- Functional assessments for those presenting with falls, frailty and general deterioration.
- Cognition assessment for those presenting with mild head injury / concussion and acute or chronic conditions.
- Extended practice roles and skills to liaise with in-reaching services, facilitate, arrange or update social care packages or recommend respite, interim placement / rehabilitation or hospice.
- Assess mobility and provide where necessary walking aid(s) for basic ADL equipment from onsite team equipment stock.
- Escalation of the deteriorating patient.

The team work in ED (minors, majors and resuscitation, Urgent Care Centre, Ambulatory Emergency Care and CDU). The service also covers Acute Medical Admissions wards. The team will accept referral based on the functional need/changes with the aim to prevent an unnecessary hospital stay.

The team is weighted with band 7's and a band 6 due to the complexity of the caseload and early decision making needs. Therapists assess patients using advanced clinical reasoning and an A&E /acute care tool, which has been benchmarked across other London hospitals and incorporates evidence based scales and outcome measures.

Results and evaluation

Outcomes

Referrals average per month	90-120
Discharge	79%
Discharge to rehab/interim care	6%
Admit	13%
Inappropriate for the service	2%

The team communicates with the patient, family and ED or Acute Medicine teams to facilitate agreeable discharge plans with the requisite support and to enable them to reach their goals.

Key learning points

Highly skilled OTs based at the front door contributes enormously to admission prevention or effecting early discharge.

Highly skilled OTs identify the multifactorial issues concerning a patients presentation and can shape effective onward MDT care (inpatient or in the community).

Plans for Spread

Due to the success of this service, recognition for OT on a sister site ED/CDU has been commissioned and implemented.

Key Contacts

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Case Study 31:
Pennine Lancashire Falls Response Service (FRS).

Understanding the problem

Falls are recognised to be a significant public health issue across Pennine Lancashire. The high levels of deprivation in both Blackburn with Darwen (BwD) and East Lancashire (EL) add significant risk factors such as poor health, poor nutrition and poor housing. In 2014 BwD Directorate of Public Health reported a higher rate of falls injury-related hospital admissions in older people than the England average (BwD Integrated Strategic Needs Assessment 2014). This is also the case in EL where the population aged 65 and over is comparable to the rest of England, but the rate of emergency admissions for injuries due to falls is significantly higher in all areas apart from the Ribble Valley (figures from LCC Business Intelligence, November 2014). FRS operates from a dedicated falls response vehicle - an unmarked car with no sirens, blue lights or controlled drugs. This ensures the FRS car is not diverted to other emergency incidents. The car is equipped with basic paramedic kit including a radio; manual handling equipment including the ELK powered lifting cushion, a walking frame, a small supply of ferrules and a selection of information leaflets.

East Lancashire Hospitals NHS Trust and North West Ambulance Service work in partnership to provide this service. Occupational Therapy staff base themselves at an NWAS base in Burnley.

Aims and Objective

Aims and Objective

- Reduce unnecessary hospital admission due to social or non-medical factors.
- Reduce the number of older people presenting at the Emergency Department following a fall.
- Reduce demand for ambulance response for green category falls incidents.
- Deliver immediate actions to support older people to remain safely at home following a fall including advice on falls prevention.
- Sign-post and/or refer to appropriate longer term support services.

Method and approach

The daily team comprises of one paramedic and one occupational therapist. The response to every incident is led by the paramedic assessment which follows the NWAS Pathfinder tool for all patients and utilises the Falls Selfcare Pathway. Whilst the paramedic assessment is being completed the occupational therapist gathers information and assesses the environment. Only

when the patient is deemed to have satisfactory observations and no injury is the functional therapy assessment undertaken. Together the team review balance, mobility and muscle weakness, evidence of UTI or chest infection, indicators of visual and or cognitive impairment. The occupational therapist takes a bio-psychosocial approach and reviews the person's functional ability from both a physical and psycho-social perspective and looks at their fears relating to falling. Assessments have picked up problems being experienced with alcohol, dementia, medication, isolation and loneliness and fire risk. Intervention includes provision of assistive equipment, liaison with relevant health care professionals, referral to other agencies and advice/information as appropriate.

Results and evaluation

Savings can be attributed to initially the non-conveyance to hospital by a Paramedic Emergency Service costing £217 per journey. Plus the Emergency Department (ED) tariff which is £126 per assessment, totalling £343. For patients who are admitted to hospital an additional £196 per night can be added for the in-patient tariff. To give an example of the potential savings, ELHT figures for April 2015 gave a 51% admission rate for patients over 65 and over who were conveyed to ED by ambulance. Based on April 2015 FRS visits (which have now increased per month), 51% of patients equalled 19 patients avoiding hospital admission, which at the lowest HRG tariff for 5 days equates to a saving of £18,696. Costs of providing the service need to be taken into account however these are significantly less than the alternative provision.

Key learning points

- Experienced staff with an in depth knowledge about community service and a willingness to take clinically reasoned risks, have been key to the low conveyance rates

- Occupational Therapists - drawing upon their holistic skills, as falls interventions can cross mental health conditions such as Dementia and Alcohol problems

- Consistency of the service and hours is critical – to ensure ambulance control remain aware of the service and refer people in

- Marketing within the ambulance service to retain the pro-active element of the service

- Close links with nursing services/social care to be able to start up immediate care packages

Plans for Spread

- Winner of the Laura Bolton award for outstanding contribution (NWAS)

- Winner of the Outstanding Innovation award at 2015 UK OT show

- Speakers at The King's Fund 'Enabling allied health professionals to lead and shape new models of care', December 2015.

- HENW Video case study 'Falls Response Service'

Key Contacts

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Rachel Bedwell, Occupational Therapist Falls Response Service.
Sam English, Advanced Paramedic.
Gail Smith, Paramedic Falls Response Service.

East Lancashire Hospitals NHS Trust (ELHT) and North West Ambulance Service (NWAS).

Case Study 32:
Radiographer reporting - Improving diagnostic capacity through team working.

Understanding the problem

Homerton University Hospital is an acute medium sized district general hospital located in east London, and serves a diverse population with complex health needs. Homerton Emergency Department was rated outstanding by the CQC and is meeting the 95% four hour target. The neonatal unit is a large, tertiary referral centre with 14,000 cot days and 3,000 X-rays in 2013.

A chronic shortage of radiologists, coupled with sustained increases in imaging workload has seen a substantial reporting backlog emerge. Diagnostic capacity is frequently cited as a barrier to improved patient outcomes and streamlined patient pathways, and limits ambitious plans for cancer diagnosis, compounds unrelenting pressures in emergency medicine and hinders improvements in neonatal care. Radiographer reporting has shown to be an effective, efficient and safe way of meeting rising demands.

Aims and Objective

Objective - to expand the contribution of radiographer reporting within the radiology department.

Aims - to meet anticipated activity increases and to maintain or improve reporting times.

Method and approach

Radiology activity and demand analysis was conducted, initially as a three year retrospective audit, then annually, identifying activity, waiting times, reporting times and the practitioner group (radiologist/radiographer/sonographer) providing the report. Activity was benchmarked against Royal College of Radiologists standards.

Based on this needs assessment, two radiographer-led services were introduced, immediate skeletal emergency X-ray reporting and neonatal X-ray reporting and to increase capacity and improve the timeliness of reports, maximising the benefit that imaging investigations have on patient management decisions.
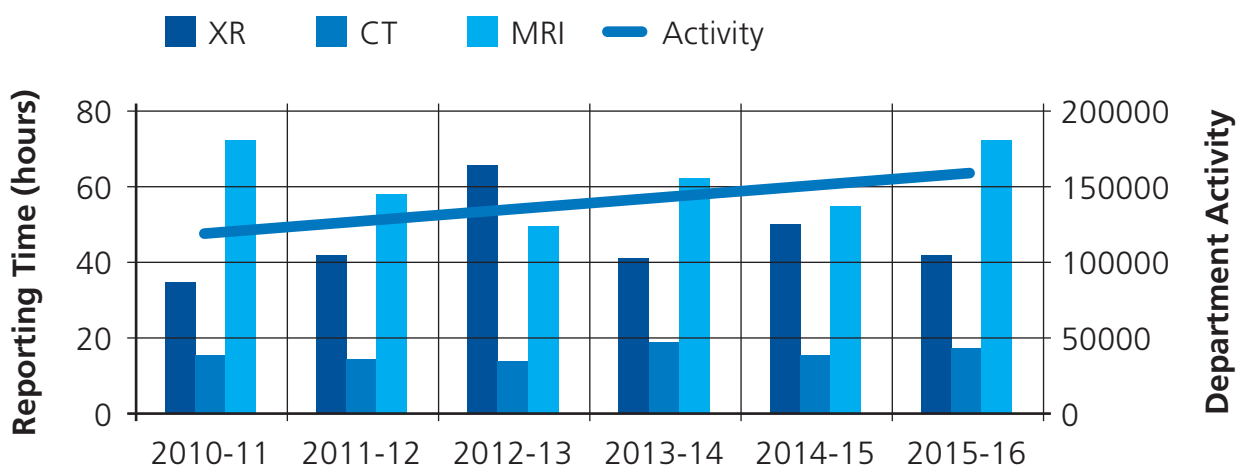
Results and evaluation

Skeletal X-rays now receive an immediate report during normal working hours, with work on-going to increase the service. This has improved patient flows through ED and reduced patient recalls.

Current average reporting times are: X-rays=34 hours, CT=16 hours and MRI=72 hours. This is against a national backdrop of significant reporting delays (170,000 waiting >30 days).

Reporting radiographer and sonographer contribution has increased, from a saving of three FTE consultant radiologists in 2013-14 to 6 consultants in 2015-16.

All neonatal X-rays are now reported, no later than next working day, with 90% reported by a radiographer. A weekly MDT meeting has been introduced, with the radiographer deputising for the paediatric radiologist in their absence.

XR CT MRI Activity

Reporting Time (hours): 80, 60, 40, 20, 0

Department Activity: 200000, 150000, 100000, 50000, 0

2010-11 2011-12 2012-13 2013-14 2014-15 2015-16

Key learning points

Team-based approach is essential within radiology, in order to meet rising demand and to maintain a patient focused service. Radiographer reporting provides a significant contribution, and has been shown to be effective, efficient and safe.

Ensuring sufficient radiographers, both for reporting and for backfill into traditional roles, is essential for a robust, reliable service. This was recognised and addressed during 2014-15 when some reporting times increased.

Plans for Spread

Homerton University Hospital is an exemplar site, nationally and internationally, for the College of Radiographers and the National Diagnostic Imaging Board. The strategy and audit results are freely available, with the results published in Radiography Journal (2014) and via the College of Radiographers (2015). The radiographer neonatal X-ray reporting service was highly commended in the British Institute of Radiology 2015 service improvement awards.

Key Contacts

Nick Woznitza, Clinical Academic Reporting Radiographer, Homerton University Hospital and Canterbury Christ Church University. Email: nicholas.woznitza@nhs.net

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Case Study 33:
Frailty Assessment Base (FAB).

Understanding the problem

This was a pilot project which took place in the newly created frailty assessment base at Ipswich Hospital. The model focuses on older people and their needs rather than service structures. The aim was to provide a service to elderly patients with complex frailty syndrome who were identified at the front door and as having longer than average hospital admissions or who are

at high risk of hospital re-admission. These patients require multidisciplinary comprehensive assessment and care co-ordination. In summary:

- 50% over 85s have frailty.
- Hospital admission associated with:
  - Longer length of stay.
  - Functional disability (lasting for >1year).
  - Higher risk readmission.
- Comprehensive Geriatric Assessment:
  - Reduces mortality.
  - Reduces admissions.
  - Increases the chance of returning home after admission.
  - Reduces readmissions.

Aims and Objective

This new model of care for these patients aims to:

- Prevent admissions.
- Reduce length of hospital admission.
- Reduce re-admission.

The service will deliver:

- A comprehensive assessment of need to support by providing assessment.
- Collaborative shared care plan.
- Support to access an appropriate package of care.
- Signposting where required.

Method and approach

The consultant led service used a multidisciplinary approach which included geriatricians, nurses and AHPs who, as a team, perform three key functions aimed at assuring patient safety:

- Triage: timely assessment with ready access to diagnostics, and triage to step-down, step-up and step-across beds as required.
- Trajectory: the multi-disciplinary assessment should identify the likely outcome for the patient based on the information available to them at the time of the assessment.
- Transfer: to the community or in to a hospital bed will take place with a clearly documented needs based assessment and plan of care, including expected outcomes. This is communicated to the team who will be responsible for that care.

Results and evaluation

The key intervention for the team is providing rapid access to a Comprehensive Geriatric Assessment via a multidisciplinary team. This team consists of geriatricians, specialist nurse, specialist occupational therapist, specialist physiotherapist, dietitian and specialist pharmacist roles. The service is accessed via the Interface Geriatrician hotline or via email and can provide either advice or same day assessment. The FAB team guarantee a 48-hour response time to email referrals. Patients leave FAB following their Comprehensive Geriatric Assessment with a copy of a Shared Care and Support Plan which is also sent to the referrer and other parties involved in their care.

Activity statistics for pilot period

From service commencement to 15/03/16, 290 patients accessed the service and of these, 35 (12%) were admitted within 7 days.

05/10/15 - 15/03/16 (FAB only)

Patients seen in FAB	Patients direct admitted from FAB	Readmissions following FAB intervention
290	14 (4 died during admission)	17

Frailty score of patients seen in FAB unit (FAB + Falls)

1	2	3	4	5 (mildly frail)	6 (moderately frail)	7 (severely frail)	8	9
1%	3%	16%	14%	19%	26%	18%	2%	0%

Direct admission length of stay (LoS), (FAB + Falls)

One of the proposed benefits of the FAB service was to reduce the LoS of patients admitted from the unit on the basis that they had already had a full work up, that baselines were completed and a plan in place.

Around 10% of patients seen in the Frailty unit are admitted into IHT. The LoS ranges between 1 and 60 days with an average of 12.39. As a comparative, the average length of stay for patients within the specialty code 430 (Geriatric Medicine) is 13.74 days. Also, it is worth noting that a 60 day and 41 day admission are included in the FAB numbers.

How likely are you to recommend our service?
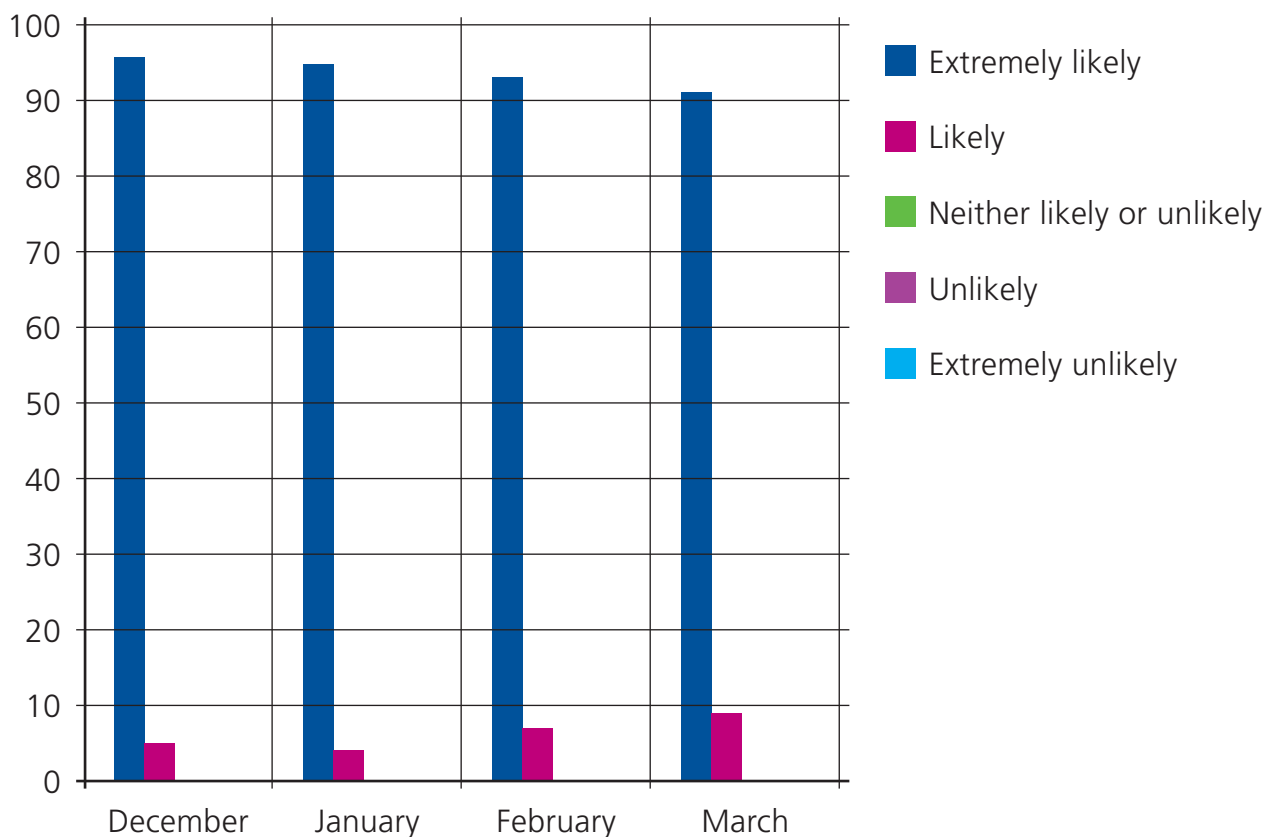
Cost impact data:

- System wide savings - realised at commissioner level based on payment by results (PBR) average, £2710 elderly inpatient stay, charge for FAB is £500 (health costs only).
- Based on activity in six month pilot - 274 prevented admissions x £2710 - costs (£225k) = saving to the system of £1/2 million.
- Reduction in system reliance on inpatient beds.

Plans for Spread

FAB2:

- Expand hours.
- Seven day service.
- Increase ED presence.
- Training hub - multiprofessional.
- Enhanced nurse and AHP roles.
- Merge outpatients.

Key Contacts

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Louise Kenworthy, Professional Lead Physiotherapist (shared role) - Integrated Therapies, Ipswich Hospital. Email: Louise.kenworthy@ipswichhospital.nhs.uk

Case Study 34:
Physiotherapists in accident & emergency use expert knowledge and skills to improve patient care and flow; preventing unnecessary admissions, restoring function and enabling independent living.

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

Case Study 35:
Breast cancer rehabilitation service

http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/cancer-survivorship

Case Study 36:
Advanced Practice in Oncology - Fulfilling the Core Domains of the Consultant Role

Understanding the problem

The Leeds Cancer Centre (LCC) is one of the largest Oncology Centres in Europe and is part of the Leeds Teaching Hospitals NHS Trust. LCC serves the 2.7 million referral population of the Yorkshire & North Trent region. LCC houses the Radiotherapy Department which is one of only three such departments across this region. The department treats in excess of 6,500 cancer patients annually, has 12 LINAC treatment machines and offers specialised services for paediatrics, commissioning through evaluation (CtE) and Gamma Knife treatments among others.

Breast cancer referrals form over 20% of the workload of this busy radiotherapy department which accounts for around 1300 patients annually. Referrals are taken from across a large geographic area by Consultant Clinical Oncologists (CCOs) who split their time between peripheral and centre based clinics and between two or more anatomical cancer sites. Set against a backdrop of high vacancy rates for CCOs nationally and the need to continually meet Department of Health cancer wait targets, whilst adapting to provide the best quality and most technically advanced treatments available. This demand and supply problem has resulted in limitations to the ambitious development plans for breast radiotherapy at LCC who are regarded as being at the forefront of innovative development and evidence based advances in practice.

Aims and Objective

Objective

To introduce a Consultant Radiographer role in Breast Oncology.

Aims

- To offer a skill mix approach that optimises the patient experience whilst streamlining the pathway for breast cancer.
- To develop a job plan that fulfils the core domains of the Consultant role.

Method and approach

- Radiotherapy referral activity for breast cancer was audited across the region.
- Process mapping was undertaken across the patient pathway from diagnosis to follow up with benchmarking against skill mix in other professions.
- Consultation undertaken locally with service leads, academics and other professional groups and nationally with professional bodies: Society of Radiographers and the Royal College of Radiologists for Clinical Oncology.
- Job plan created based on needs assessment with dedicated time for clinical practice at LCC but also at peripheral referral centre alongside CCO to increase resource.
- Dedicated, funded, time to Sheffield Hallam University (SHU) to provide education resource and R&D partnership.

Results and evaluation

A full job plan now offers the Consultant Radiographer resource to LCC and Huddersfield Royal Infirmary of a maximum of 10 new patient referrals for breast radiotherapy a week. In addition this allows clinic time for on treatment toxicity reviews and follow up clinics for standard and trial based

patients. Figure 1 highlights those points of the breast cancer patient pathway at LCC where skill mix roles are now in use to reduce patient handovers in care and streamline the pathway for the patient. The role of the Consultant Radiographer in the multi-disciplinary team (MDT) is also critical, providing the expert input in these multi-disciplinary forums to optimise the quality of care offered to these patients.

Fig1. Points of the breast cancer patient pathway at LCC where skill mix roles are now in use (indicated by colour mix).
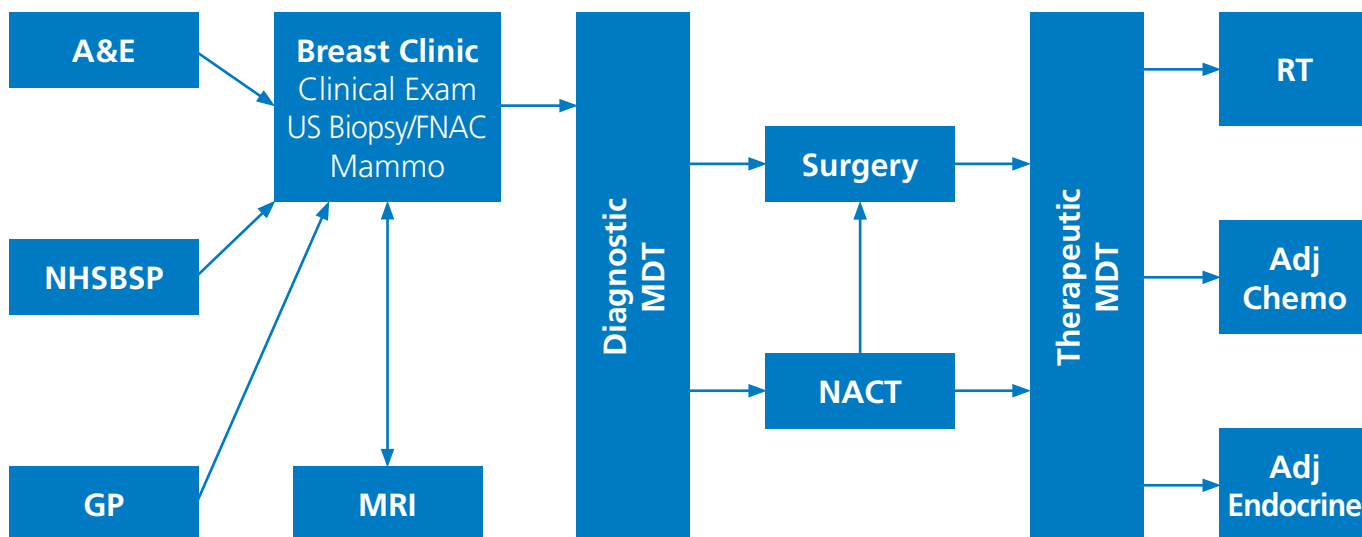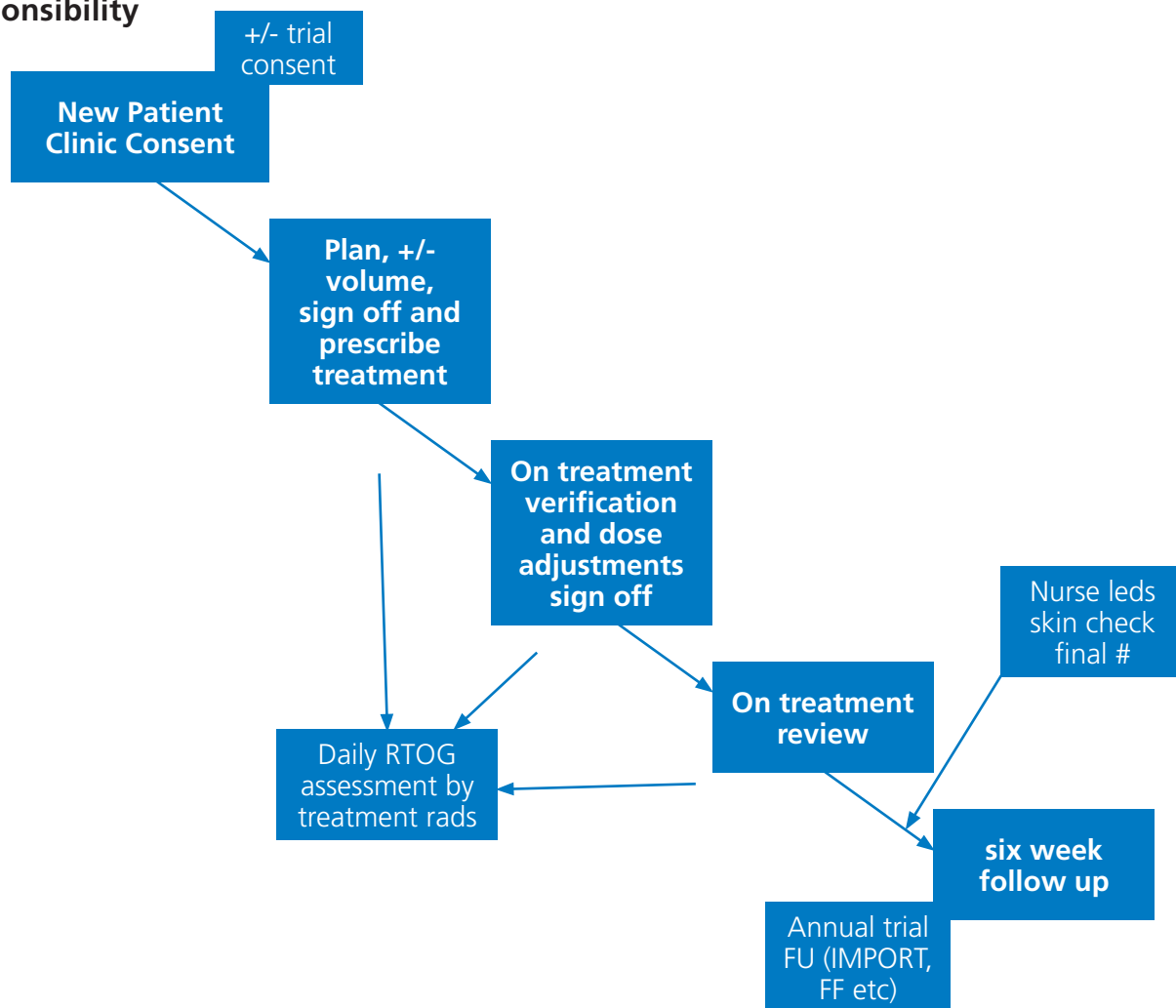

Figure 2 illustrates the extent of the patient pathway in radiotherapy for which the Consultant Radiographer takes responsibility as referrer, in an autonomous capacity without the need for a CCO.

Fig 2. Patient pathway in radiotherapy for which the Consultant Radiographer takes responsibility

Quarterly audit and patient satisfaction survey have provided evidence of the beneficial effect of the role both in terms of additional resource but also of quality of care.

The partnership with SHU has also allowed for additional teaching and supervision resource for BSc and MSc students undertaking radiotherapy based courses but also for breast cancer specific post graduate modules where a clinical expert can provide academic resource but also mentorship and support.

Furthermore the role has allowed for dedicated service development work at both a local and national level. The radiography profession and LCC in particular have been represented during national guideline development work and in NICE consultation for early and advanced breast cancer management through this role. It has also provided LCC with its first therapy radiographer trial PI on an upcoming national breast radiotherapy trial.

Key learning points

The creation of a relatively new skill mix role for the profession must be adequately planned in terms of local service need and the benefit that can be offered. Beyond this, infrastructure for the role must be conceived at the earliest opportunity within the role creation process. In this example, the links with the local HEI has been instrumental in realising the breadth of the core domains for consultant practice. The importance of a competency framework cannot be underplayed both to ensure appropriate governance and transition for the post holder but also to provide engagement and acceptance of such a new role to the wider MDT.

Plans for Spread

The example provided in this case study represents the appointment and development of the first Consultant Radiographer in Oncology for this region and the first nationally within Breast Oncology. It is intended that the template provided from this training and job plan creation can be used for the appointment of subsequent posts locally into different specialisms within Radiotherapy and Oncology. Nationally we have seen a recent exponential rise in the number of Consultant Radiographer posts in Oncology and they now stand at over 20.

Details of the development framework undertaken for this role have been published and are freely available in The Journal of Radiotherapy in Practice (2016). Work continues with professional bodies to develop the training needs and role structure for these posts.

Key Contacts

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Case Study 37:
Therapeutic radiographers in site specialist roles - Improving patient care.

Understanding the problem

The Christie NHS Foundation Trust is a specialist cancer centre with 97 in-patient beds, providing specialist treatment to over 40,000 patients each year. The centre comprises of a large 'main site' and two 'satellite centres' which provide Radiotherapy Treatment (RT) to a local population of 2.5 million, predominantly in the north west of England. The 'main site' comprises of 11 linacs; with a total of 103,791 RT treatments administered between April 2013 and March 2014. As a specialist cancer centre, The Christie has encouraged the expansion and development of Therapeutic Radiographer's roles; these include a wide variety of advanced and specialist practice roles. Specialist practice roles at the Christie include site specific, research, patient review, specialisation within pre-treatment and treatment delivery, including planning and brachytherapy.

Radiotherapy services vary in terms of quality and access for patients. Many drivers for improvements in quality are focused on the technological developments of radiotherapy treatments, whilst patient care and support can be left behind. The Department of Health's Improving outcomes: A strategy for cancer, recognise that there are variations in patients 'experience of care and services should reflect what's important to patients. The independent Cancer Taskforce's published cancer strategy for England (2015-2020), calls for patients to have access to a Clinical Nurse Specialist (CNS) or other key worker to help coordinate care. Therapeutic radiographers are recognised as being able to deliver co-ordinated care, particularly in the advent of fewer clinical nurse specialists for prostate patients compared to other sites such as breast cancer patients. These advanced roles are also developing to take on traditional clinician-led services such as on-treatment review. Indeed key areas identified for therapeutic radiographers to undertake included on-treatment review clinics, information giving, and clinical assessment of side effects as well as holistic support.

Aims and Objective

Objective - A prostate specialist radiographer was appointed to set up radiographer-led on treatment review clinics.

Aims - To develop a service that is patient centred and fits the needs of the radiotherapy department.

Method and approach

1. Scope the current clinician-led service.
2. Identify areas for development.
3. Implement new radiographer-led service.
4. Obtain patient and therapy radiographer feedback on new radiographer-led service.
5. Assess the value of the new radiographer-led service.

Results and evaluation

Patient survey results

All 21 patients were White/British and 5 patients were aged 60-69 with a majority of 15 aged between 70-79 and one gentleman 80+.

Timing and access to review:

- 100% of the patients felt they had sufficient time during the review.
- Some patients felt they didn't need to be seen every week during treatment (n=12) 57%.
- A few patients (n=4)19% did see the specialist radiographer more often than planned due to ad-hoc queries/worsening side effects needing further interim review.
- All four patients (19%) who did require extra input felt the specialist was easy to access.

Person reviewing.

- 100% of patients agreed the specialist radiographer reviewing them could answer their questions.
- 100% of the patients felt comfortable to discuss any concerns with the specialist radiographer.
- A majority of patients wished to see the same person each week for their review (n= 15) 71%. The rest of the patients (n=6) 28% said they didn't mind.

Radiotherapy staff survey results

15 therapeutic radiographers completed the survey.

Timing and access to specialist radiographer.

- 100% of staff felt patients got better access to and support with a specialist radiographer in post.
- 100% of staff felt it was quicker to get hold of somebody from the clinical team when the specialist radiographer was the first point of contact.
- The majority of staff (n=14) felt the specialist radiographer could answer all queries usually directed to the doctors. One staff member answered "I don't know".
- The majority of staff (n=13) felt it was easier to manage their linac diary with the specialist review clinics which synced with the Linac times (8am-6pm).Two staff answered "I don't know".

Key learning points

The support patients require whilst undergoing radiotherapy for prostate cancer is individual to each of them. With some patients requiring more support and information than others. The RCR recommends at least weekly reviews however for some patients' more than weekly reviews where required (19%) whereas others may only require alternative week reviews (57%) and therefore all patients should be offered weekly visits but some may not need to be seen weekly. For example in their first week of treatment when the have little/no side effects. This should be considered when planning services.

Specialist radiographers are important to both patients and staff who felt they allow for continuity of care, ease of access and the flexibility to carry out ad-hoc reviews if required for patients who need extra support.

This role is highlighted in the Society and College of Radiographers publication The Prostate/ Urology Specialist Cancer Workforce: Provision of Specialist Therapeutic.

Plans for Spread

The local service is looking to expand with radiographers entering more site specialist roles as the demand of patient load is every increasing.

This role is highlighted in the Society and College of Radiographers publication; The Prostate/Urology Specialist Cancer Workforce: Provision of Specialist Therapeutic Radiographers in the Treatment and Care of Men with Prostate Cancer (2015) available at: http://www.sor.org/learning/document-library

This Prostate Urology (2015) report has demonstrated that prostate/urology specialist Therapeutic Radiography roles are reliably in place in eighteen cancer centres, mostly in England, and their numbers are increasing. The majority of posts have been created out of the existing radiographic establishment with the role not yet sustainably embedded and might best be described as emerging. There is also quantitative data available including:

- Estimated volume of prostate cancer new patient referrals.
- Treatments offered for prostate cancer.
- Numbers of site-specialist posts including prostate/urology at March 2015.
- Cancer centres with either prostate and/or urology specialist roles.
- Rationale for development of posts.
- How posts are funded.
- Future plans for new site specialist posts within three years.
- Number of site-specialist posts across tumour types - current and planned.

Key Contacts

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Case Study 38:
The implementation of a Consultant Radiographer to an established service.

Understanding the problem

Shortage of radiologists in breast imaging services causing problems in service delivery. Imminent retirement plans and service expansions made this problem immediate and a significant risk to the future provision of breast services. Although radiographer advanced practice had been implemented and utilised successfully in the department a consultant practitioner was a new investment. Problems included cancelled clinics and long waiting lists for some interventional procedures.

Aims and Objective

- Improve the flexibility of service delivery.
- Reduce the number of clinics cancelled.
- Reduce waiting times for interventional procedures.
- Provide a more integrated and cohesive service.
- Improve patient experience.
- Cost effective service delivery - all staff are used according to their skill set.

Method and approach

The consultant radiographer post was new to the trust and although it is a role in its own right is intended to work as an integral part of the multidisciplinary team implementing its own unique skill set. When I was appointed, time was taken to manage expectations of my role for both myself and the wider team. A lack of understanding of the role of a consultant practitioner was clear but the trust team were willing to work with me to make best use of my skills. The value of the four core components was discussed and how these would be utilised to integrate the consultant practitioner role into a successful and well established team. My job plan included my working with all breast surgeons in a variety of clinics and multidisciplinary team meetings. This helped me to demonstrate that the level of clinical practice consultant practitioners show is consistent with a breast radiologist within the context of breast imaging.

Results and evaluation

There was an immediate reduction in the number of clinics cancelled. As my clinical role is exclusively in breast imaging my non-clinical sessions allow increased flexibility in my clinical workload. Radiologists usually have a commitment to other general radiological workloads which are often non-negotiable. As I am based in the breast imaging department I represent a form of continuity and a conduit between the staff groups. Colleagues report an improvement in workflow and communication. User experience is improved because additional sessions are easier to implement and less cancellations reduces anxiety levels. Patients also receive a high quality service.

Feedback from recent appraisal;

"The role that the consultant radiographer fulfils has had an immense impact upon the service delivery within the mammography department. This has ultimately been due to the consultant being solely responsible to the mammography department and therefore is able to see areas for improvement whilst having the time to be able to put these into action. The consultant is able to have a view point that is not noticeable from radiologists as to the impact new ideas may have. The 'gap' between the roles is not so great between mammographers and the consultant which allows a greater team work ethic than with radiologists. The department moral is far improved due to not having to 'compete' for consultant's time which happens with radiologists. The consultant radiographer has a greater understanding of the issues experienced by the staff, which allows for a greater support for change."

Key learning points

Skill mix is a highly effective means of service delivery in modern healthcare. Appropriately trained individuals can help sustain and improve service delivery. The biggest draw-back is my inability to put the breast findings into the context of the wider systemic disease development, but by working closely with my radiology colleagues this has not proven too problematic. Succession planning is challenging as there is no money to invest in training which takes years to achieve consultant radiographer status.

Plans for Spread

My plan would be to continue to develop the skills of the staff to best effectiveness and to consider different ways of service delivery in the future to best utilise our resources.

Key Contacts

Sue Williams, Consultant Radiographer, Shrewsbury and Telford Hospital NHS Trust.
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Case Study 39:
Keeping people with altered airways safe in their homes.

Understanding the problem

The South East London Community Head and Neck Cancer Team (CHANT) is a community specialist rehabilitation team supporting patients with head and neck cancer who are living with and beyond cancer. The service was launched in 2010, jointly funded by SE London's six CCGs, Lambeth, Southwark, Lewisham, Bromley, Bexley and Greenwich and is run by Lewisham and Greenwich NHS Trust in partnership with Guy's and St Thomas' NHS Trust, to provide seamless care from hospital to home following a patient's cancer treatment.

The team comprises speech and language therapists, dietitians, physiotherapists, clinical nurse specialists and administrators and provides multidisciplinary support, symptom control, advice and specialist rehabilitation for patients who have undergone treatment for head and neck cancer. Patients are seen in clinics local to their homes, or on a domiciliary basis, depending on the needs of the individual patient to help them reach their potential in recovery. CHANT offer all patients a post treatment holistic needs assessment to help plan care and a health and wellbeing event appointment at the end of their rehabilitation.

CHANT is the only comprehensive community head and neck service of its kind in the UK, bringing specialist care and rehabilitation closer to the patients' home.

A percentage of patients who undergo treatment for head and neck cancer have altered airways and breathe through a hole in their necks. This can be a permanent change such as with laryngectomy where the voicebox is removed, or longterm/ temporary such as with tracheostomy. This patient group is highly vulnerable, as individuals are required to adjust to breathing through a hole in their necks, and learn how to care for the tube, keep it clean and clear of secretions to prevent blocking, operate medical equipment such as suction units, and keep themselves

safe and able to breathe. This is often overwhelming for patients after the safe environment of a ward, despite indepth training prior to discharge. Additionally as an altered airway is not common, district nurses and carers often feel unsupported and are concerned about caring for this group of patients.

When CHANT started, we noted that patients commonly bounced back into hospital within the first 24-48 hours post discharge, and this was largely due to patient's lack of confidence in managing the tracheostomy in the home setting or the equipment not working. Also patients had a protracted length of stay while waiting for district nurses to be adequately trained in tracheostomy management. Both of these issues resulted in additional cost, and poor patient experience.

Aims and Objective

As CHANT's ethos was to offer a local specialist service to support patients at home, the team identified that an early visit within the first 24 working hours post discharge from hospital would be beneficial, with the main objectives to ensure:

- Patient confidence and competence in managing the tracheostomy at home.
- Correct set up and operation of medical equipment.
- Face to face training of district nurses with the patient.
- Introducing CHANT as identified support for patient, carers and community health care professionals.

Method and approach

The team identified protected appointments for an 'airway visit' across the week, Monday - Friday, 9am - 5pm. This was shared between the tracheostomy competent team members (physiotherapists, SLTs and CNSs), so that each member of staff had one allocated slot each week. An airway visit protocol was agreed to standardise management at each visit. This included:

- Ongoing tracheostomy rehabilitation.
- Equipment set up and review.
- Review of tracheostomy competencies with the patient.
- Troubleshooting clinical issues.
- Registration with the London Ambulance Service.
- Family support.
- Reassurance.

This was shared with the head and neck surgery ward via the Tracheostomy MDT. If the team was unable to visit within the first 24 hours eg due to staff sickness, the ward was able to risk assess and agree a visit within 48 hours or keep high risk patients on the ward for another day.

Results and evaluation

The team was able to show a cost saving preventing hospital readmission through their intervention, and a better patient experience, increasing their confidence once home.

Service evaluation January 2013 to December 2013.

- 13 new airway referrals received over the year.
- 85% seen within 24 hours (2 not).
- 92% required active clinical intervention, which prevented potential hospital readmission.
- No hospital admission required on first visit.
- First airway visit carried out by SLT 45%, CNS 13%, PT 42%.
- Visit lasts 1.5 hours plus travel, paperwork and liaison.
- 1-4 visits from the team during first week (these were to proceed with eg communication/ swallowing rehabilitation, symptom management, while continuing to support individuals with their tracheostomy.
- No hospital readmissions due to tracheostomy issues.

Patient evaluation:

- "I felt quite overwhelmed with all the equipment I came home with but they kindly showed me how to use it all and even set my suction machine up".
- "I was very very pleased with the service I got and think it is a wonderful idea to have a team in the community. Many many thank you to you all".
- "This was an excellent service provided by experienced professionals in the head and neck field of play. I am a happy customer! Thank you".

Key learning points

- Ensuring protected appointments stay ringfenced - at times where there were no tracheostomy patients being discharged, staff appropriately filled these appointments with other clinical activity - however once a patient with a tracheostomy was imminently being discharged, some staff needed support in reclaiming these appointments.
- Highlighted a gap in provision for patients living in the community with a tracheostomy for reasons other than head and neck cancer - as the team are not commissioned to see these patients, they do not have an equitable service and frequently bounce back into hospital.

Plans for Spread

Presented at the 9th International Head and Neck Cancer Quality of Life Conference 2014.

Key Contacts

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Case Study 40:
Recognising and addressing the social impact of eating and drinking difficulties.

Understanding the problem

The South East London Community Head and Neck Cancer Team (CHANT) is a community specialist rehabilitation team supporting patients with head and neck cancer who are living with and beyond cancer. The service was launched in 2010, jointly funded by SE London's six CCGs, Lambeth, Southwark, Lewisham, Bromley, Bexley and Greenwich and is run by Lewisham and Greenwich NHS Trust in partnership with Guy's and St Thomas' NHS Trust, to provide seamless care from hospital to home following a patient's cancer treatment.

The team comprises speech and language therapists, dietitians, physiotherapists, clinical nurse specialists and administrators and provides multidisciplinary support, symptom control, advice and specialist rehabilitation for patients who have undergone treatment for head and neck cancer. Patients are seen in clinics local to their homes, or on a domiciliary basis, depending on the needs of the individual patient to help them reach their potential in recovery. CHANT offer all patients a post treatment holistic needs assessment to help plan care and a health and wellbeing event appointment at the end of their rehabilitation.

CHANT is the only comprehensive community head and neck service of its kind in the UK, bringing specialist care and rehabilitation closer to the patients' home.

Head and neck cancer and its treatment can the ability to eat, drink and swallow normally due to changes or removal of the structures needed for eating, dry mouth, changes in taste and pain. These effects are long lasting and a number of patients will require a feeding tube into the stomach on a long term basis to replace or supplement what they can manage by mouth. The speech and language therapist and dietitian work closely with individuals to rehabilitate swallow function , optimise swallow safety and ensure nutritional needs are met.

For most patients it is not possible to rehabilitate swallowing back to normal function. As eating and drinking serves an important social function in humans over and above simply taking in nutrients, not being able to eat has far reaching effects on the family unit, ability to socialise with friends, ability to return to work. The team were obtaining good rehabilitation outcomes, and however recognised that rehabilitation alone is not enough if the gains made do not translate into being able to do things which are meaningful to the individual, for example being able to eat with their family.

Aims and Objective

The SLTs and dietitians on the CHANT team developed an 'eating group' education and support programme, aiming to provide education around effects of head and neck cancer treatment experienced by individuals and potential solutions within a peer supported environment, focusing on eating in a social context.

Method and approach

Patients who could manage a modified diet only (eg pureed diet) were invited to the group, which was a three hour education and support programme, with the following aims:

- To increase participants' knowledge of appropriate food and menu choices following treatment for head and neck cancer.

- To provide the opportunity for participants to meet with others who have had similar treatment, for peer support and discussion.
- To promote self-management and support survivorship.
- To increase CHANT's understanding of participants' needs and concerns around eating and drinking following treatment for head and neck cancer.

Results and evaluation

Data were collected from participants using pre and post session questionnaires. Confidence rating scales (0 = not confident, 10 = very confident) were used to measure baseline and outcomes pre and post group. Qualitative data in the form of comments on the questionnaire forms were used to draw out particular themes common to participants as well as individual issues which may have required follow-up.

Quantitative data

Main problem when eating and drinking	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Totals
Dry mouth	1	1	0	1	1	1	5
Food choices	0	1	0	1	1	1	4
Taste	1	1	0	0	1	1	4
Pain	1	1	0	0	0	1	3
Coughing	1	1	0	0	0	0	2
Dentition	1	0	0	1	0	0	2
Other	0	1	1	0	0	0	2

The most common problem reported by the group when eating and drinking was dry mouth. The problems classed as "other" are recorded in the qualitative section below.

Although there were some individual cases of deterioration in confidence, overall the group showed increase in confidence across the areas measured.

Timing	Participant	Confidence in choosing foods at home?	Confidence in choosing foods eating out?	Would you ask for menus to be adapted for your needs when eating out? / Do you feel more confidentin doing this now?	Confidence in choosing meals which are nutritionally balanced?
Pre	1	7	6	No	7
Post		8	7	Maybe	8
Pre	2	3	2	No	3
Post		2	3	Maybe	3
Pre	3*	7	2	So far not attempted	6
Post					
Pre	4	7	5	Yes	5
Post		7	5	Yes	7
Pre	5	2	5	Yes	1
Post		4	6	Maybe	0
Pre	6	5	0	No	6
Post		10	6	Yes	10

■ Improvement

■ No change

■ Deterioration

■ Response not yet recorded

Qualitative Patient Feedback

Three things to take away:

- The experiences of others are similar to mine/new suggestions on food/help is available.
- Mashing food before eating it/using sauces/plenty of gravy.
- How important a balanced diet is.
- Encourage myself/explore more diet/contribute and research on the internet.

Advice to give to someone who has had similar treatment to you:

- Don't feel cut off. Be prepared to take the help that is available.
- Just hoping it will improve soon.
- What I have tried to eat and how I got on.
- I would say not to give up but to keep trying. Seek advice and join a support group.

Any other feedback:

- Useful meeting people 2 years out - provides a breath of fresh air, provides hope and confidence, information sharing, allow to share problems and understand differences.
- I haven't met other people who have been through this -I'm not alone.
- Nothing to compare against unless you come to something like this - you don't know how well you are doing.
- Helped me to have patience… accept that I won't get back to normal, there is a new normal.
- The eating group gave me a real lift.

Due to the positive feedback gained, the eating group has been rolled out as part of the rehabilitation package, and all patients with ongoing swallowing difficulties are offered the opportunity to attend.

Key learning points

The group was labour intensive to set up and staff, and this needed to be resourced within the current staffing of the team. Each event involves significant administration time, therefore this needs to be built in when considering rollout.

Plans for Spread

Presented as a poster at the British Association of Head and Neck Oncologists study day May 16 2016 and the 10th International Head and Neck Cancer Quality of Life Conference 2016.

Nominated for a Trust quality award 2016.

Key Contacts

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Case Study 41:
Partnership working to deliver public health and fire safety checks.

Understanding the problem

Evidence from Manchester Mental Health and Social Care Trust (MMHSCT) and Greater Manchester Fire and Rescue Service (GMFRS) identified that people who experience mental health problems are more likely to suffer death or injury caused by fire than others living within our communities. It has been reported that since 2000 over 30% of people killed by fire in Greater Manchester were known to mental health services (GMFRS, 2009). People with mental health needs are more at risk of fire if they:

- Leave cooking unattended/burn food.
- Smoke.
- Have burn/scorch marks on bedding/furniture.
- Have memory impairment.
- Live alone.
- Don't have working smoke alarms.
- Drink alcohol.
- Use substances.
- Take medication.

Aims and Objective

A partnership has been established between Manchester Mental Health and Social Care Trust (MMHSCT) and Greater Manchester Fire and Rescue Service (GMFRS) to reduce the risk of fire for service users. This includes the implementation of a referral pathway that promotes joint working where both organisations can refer into each other and share information when needed. The original aim was to reduce harm from fire and help GMFRS understand mental health better and signpost people appropriately, and assist MMHSCT to identify signs of fire risk. Further examination of fire statistics showed that people who are at increased risk of fire had multiple issues and it was realised that there was further potential to meet broader public health priorities.

Method and approach

In Greater Manchester GMFRS and MMHSCT now carry Safe and Well checks including dementia, falls prevention, social Isolation, home security, housing and warmth. Service users can request these checks independently or mental health staff will carry out joint visits if required.

If there are multiple and interrelated factors which may lead to a person being at risk due to fire i.e. from person, their occupation and/or their environment, colleagues can request an occupational therapy assessment. Occupational therapists have received fire risk training and are able to consider this as part of an occupational therapy assessment in partnership with the Fire and Rescue Service. Occupational therapists carry out joint visits with the fire service including a Safe and Well check and incorporate these findings in to their occupational assessment and report.

Results and evaluation

Health and wellbeing outcomes:

- The fire service has developed an online training session for all health staff to raise awareness of fire risk.

- Adoption of Making Every Contact Count principles.

- MMHSCT staff trained in fire awareness to incorporate within home assessments.

- GMFRS staff are being trained in mental health awareness.

- Fire service staff have received advice on falls prevention and make referrals to the falls service.

- Joint public campaigns on public health and fire safety.

- GMFRS are currently involved in a Winter Warmth pilot (commissioned by PHE) that is currently being evaluated. During Safe and Well visits GMFRS staff provide brief advice and signposting where needed to address unmet need in relation to cold homes.

Quality of care outcomes:

- Increased partnership working between organisations, as meeting rooms are shared, cooking sessions for service users undertaken in fire station premises.

- Web-ex sessions developed and run to disseminate practice and learning to improve care more widely.

- MMHSCT website store and disseminate good practice.

- The relationships built between the fire service and partners in the public sector have seen a move to a position where there is investment to deliver an integrated approach to helping local people.

- Development of occupational therapy placement in the GMFRS supervised by MMHSCT occupational therapists to assist GMFRS in delivering Safe and Well checks i.e. develop skills in person centred and holistic approach, promoting helpful health and wellbeing conversations and an understanding oif how occupation affects fire risk.

Key learning points

Strengthening partnerships between fire and rescue services and health and social carer services, particularly utilising the skills of occupational therapists to deliver on public health and wellbeing for vulnerable groups.

Plans for Spread

Shared with:

- The College of Occupational Therapists for Occupational Therapy: Improving Lives, Saving Money Campaign. Shared with Public Health England.

Key Contacts

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Case Study 42:
Walk Faster, Walk Further 10,000 steps a day.

Understanding the problem

Our 'Walk Faster, Walk Further 10,000 steps a day' initiative was developed after interrogating our population data and considering key public health messages. There are a high proportion of obese people within secure inpatient mental health settings. Further analysis revealed that the majority of patients had very sedentary lifestyles. Life expectancy for inactive people is less than those who are active. Life expectancy for patients with mental health conditions is also significantly reduced. Motivation in this group of patients can be very poor.

Using the Simple Assessment of Physical Activity (SIMPAQ) tool across a typical ward it became apparent that many of our patients were inactive or participating in seated activity for up to 22 hours per day despite the fact that many forms of physical activity are available throughout the week. On questioning staff and investigating activity using pedometers it was realised that some staff were equally as inactive and were not aware of the benefits of walking.

Aims and Objective

We knew through experience that simple messages such as '16 laps of the courtyard is a mile' and 'walking and talking' messages had been well received by both patients and staff. Previous St Andrews research involving physiotherapy had shown that extra support to encourage exercise on wards was useful in increasing activity levels and participation. The initiative was developed from here. The simplest approach is often the best and getting our population to "Walk Faster, Walk Further" was our chosen message. It is an initiative that any member of staff can use, needs little risk assessment, has national guidance and recognition and is relatively cost neutral.

Method and approach

The necessity of health promotion was recognised. A logo was professionally designed and used to promote the initiative; it was added to email, screen savers, posters and t-shirts across the charity as both formal and informal publicity. The t-shirts were a talking point and soon became 'hot property', we used them as the physiotherapy team uniform and as incentives to get people involved in organised walking activities across the wards and grounds. Seated exercise programmes as an alternative for our less mobile patients and wheelchair users were also created. Walking routes were mapped, measured, printed out and distributed for patient and staff use.

AHP colleagues wore the promotional t-shirts and were instrumental in the success of the initiative and promoting Making Every Contact Count (MECC). In addition to internal communications we utilised Twitter and other social media to gain momentum using #StAndrewsActive. We walked and talked, or exercised with patients on our launch week and provided health promoting messages.

We challenged patients, health care professionals, ward, admin and support staff to compete against each other and collectively 'Walked to Rio' during the run up to the Olympics. Our initiative gained momentum as the total number of steps walked increased with each subsequent week. The launch of our 'Walk Faster, Walk Further 10,000 steps a day' incentives programme was the next phase allowing wards to use resources already developed to influence behaviour and promote the importance of physical activity.

Results and evaluation

- Anecdotally there have been changes in ward attitudes with an increasing number of conversations around activity and increases in levels of staff activity reported. The use of pedometers, step measuring watches/devices has increased.

- Reports that patient behaviour across different wards has improved with fewer alarm calls noted. This is yet to be analysed in detail to see if there is statistical significance.

- Cardiovascular fitness assessed by the physiotherapy and sports and exercise therapy teams has greatly improved with some individuals.

- Other people began to talk about using activity and some have added more into their daily routines.

- Additional health messages were woven in and MECC conversations are being recorded.

- AHPs began to look at increasing physical activity within their sessions, changes to timetabling and a radical change in the use of physiotherapy resource has led to an increase in physical activity for many patients.

- The initiative was a collective effort and as a result staff groups improved communication by being given a common and simple objective.

- Wednesday walk @ 1 (WW@1) has continued the promotion of activity. Spin off walks from this can be seen in the timetabling of activity.

- Patient engagement has improved as the activities have proved enjoyable and sustainable.

- Rufford ward walking group in Nottinghamshire, run by the whole ward team, and encouraged by the physiotherapist in conjunction with the Walk Faster, Walk Further initiative, recently won 'team' category at the Kate Granger Compassionate Care awards.

- Boardman multidisciplinary team wanted to promote physical activity and started a WW@1 purchasing incentives from the ward budget to ensure longevity.

Key learning points

- Use population data to support your theme.

- National statistics can be used to influence others and gain support.

- Be clear about your message and develop an accessible logo.

- Patient and staff health and wellbeing is a common goal to use.

- Senior management buy in is a must!

- Keep control of how the logo is used in order to maintain the value.

- An understanding of behaviour change is useful in health promotion.

- Keep it simple.

- Remind yourself of the goal at all times as initiative drift is common.

- Health promotion with events appears to have a wider reach and is therefore good use of time.

Plans for Spread

St Andrew's senior management team and executive are fully supportive of the initiative recognising the need for continual input.

Key Contacts

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Case Study 43:
Challenging traditional approaches to care practice for people with dementia.

Understanding the problem

Dementia is a terminal and neurodegenerative condition which progresses through mild, moderate and advanced stages, with life expectancy after diagnosis ranging from three to nine years. It is widely accepted that people with dementia (PWD) and their carers often feel socially isolated as a result of their illness. Since 2012, Music in Mind has actively addressed this issue by using music as a conduit for communication between people, as well as aiming to improve mood and cognitive functioning, reduce medication use and reduce reliance on health services.

The project uniquely brings together the clinical expertise of a music therapist alongside a professional musician from the orchestra. Projects run over 10 to 20 week periods with sessions in care homes and community centres involving eight to ten PWD and a carer. The sessions unfold organically as the participants experiment with rhythm, pitch and texture using good quality percussion instruments. This approach ensures that every member of the group is involved even if they have very limited verbal or physical skills.

Carers (both professional and family members) actively take part in the sessions and receive training throughout, in other to understand how each PWD interacts with music and to be able to continue using music in between our visits. Carers have started running their own music sessions outside of Music in Mind and we are developing a resource to support this process.

Key Funders to date:
• Tameside MBC Public Health.
• Rochdale CCG Social Investment Fund.
• Henry Smith Charity.
• Care UK.

Aims and Objective

Aims:
• improve the quality of life for PWD;
• improve client care;
• improve PWD's ability to communicate with others; and
• reducing participants' reliance on NHS services.

Objectives:

- improve PWD's mood and cognitive functioning;
- reconnect relationships between PWD and carers/ family members;
- reduce PWD's use of medication; and
- support carers to develop skills to lead own music sessions in care homes.

Method and approach

PWD often lose a large amount of control in a care home environment, but Music in Mind helps to restore their confidence and lift their mood by using improvisation to empower them to take the lead in their own creative experience. We have found that PWD's mood can be heightened to such a degree that they no longer need to take medications such as anti-pyschotics, and feel comfortable not to attend other services such as stroke therapies.

Delivery of sessions both in care homes and community centres pose their own challenges:

- Inconsistencies in care homes between quality of care received and staff capacity leads to varying degrees of support for project.
- Care homes often do not have a separate space away from the lounge from which to run a music session.
- PWD living in the community are often unable to travel to community centres.

Results and evaluation

Evaluations are regularly conducted by the University of Manchester, New Economy and HKD Research Ltd. In every project since 2012, carers of PWD have reported significantly increased levels of communication and social interaction. Other regular outcomes include increased activity levels outside of Music in Mind sessions, greater sense of wellbeing and increased confidence to express oneself. We are developing our evaluation methodologies further to be able to more successfully capture impacts on medication use and access to health services.

"Last week one lady became very active and verbal, never previously heard her talk".

 "Resident has had music therapy, does not need to be medicated".

"We've got a couple of ladies, one especially whose very depressed, she started going to the music sessions and you wouldn't believe it's the same person." (New Economy, 2015)

"100% of community participants and 75% of care home residents felt that the sessions had improved their relationships with their carer/family member".

"One care home stated their residents no longer needed to access hospital outpatient appointments, including stroke therapies, because of their involvement with Music in Mind" (Rochdale evaluation, 2015).

We began a PhD studentship with the University of Manchester in 2015 which involves creating an 'in the moment, multi-sensory tool' to measure the impact of Music in Mind on PWD, using innovative data collection methods such as the use of video and involving the participants directly in the evaluation process.

Key learning points

The future sustainability of Music in Mind is becoming ever more important. In order to reach more PWD, we must continue to develop our training resources to be able to support carers to deliver their own sessions in care homes and community centres. Carers have requested a musical resource (such as improvisatory backing tracks) to help them with this process, and we are in discussions about how to make this a reality.

We have learnt that it is essential to put the PWD and their carer first at all times. We should never assume that because we are offering a free service, the care home will make everything happen perfectly for us. New challenges arise every day that must be dealt with through open conversations with all staff members. It is crucial not to parachute in to a care setting unaware of its operations and care procedures, instead we must immerse ourselves in the care home environment in order to understand how to achieve the best result for everyone involved.

Plans for Spread

'Probably Britain's most adventurous orchestra' (The Times) and a Registered Charity (no.503675), Manchester Camerata aims to 'redefine what an orchestra can do'. Our pioneering, research-led Camerata in the Community programme engages young and older people in projects which improve their health and wellbeing through music. The programme reaches over 30,000 people each year across the North West and has received coverage from BBC North West Tonight and The Guardian and has been shortlisted for an RPS Award.

Music in Mind was nominated for an RPS Award in 2015. The project is regularly shared through articles and presentations at conferences such as:

• Enterprise Music Scotland Conference 2016

• NHS NW R&D Conference, September 2015 and 2016

• First International Conference on Arts and Dementia Research, March 2017

Wythenshawe Hospital and Royal Bolton Hospital have also contacted us with a desire to take part in Music in Mind in order to stimulate their patients living with dementia whilst in hospital, and this work should begin in early 2017.

www.manchestercamerata.co.uk

Key Contacts

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• Professor John Keady, Professor of Older People's Mental Health Nursing University of Manchester

• Dr Stuart Eglin, Director, NHS NW R&D

• Trish Dwyer, Acute Care Service Manager, Manchester Mental Health and Social Care Trust

• Marie Coleman, Project Manager, Greater Manchester Dementia Action Alliance

• Christopher Davidson, Lead Dementia Nurse, Royal Bolton Hospital

Case Study 44:
Greenview Intermediate Care Unit.

http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-works/dementia-care

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Case Study 45:
Transforming eye care to children with Special Educational Needs (SEN).

Understanding the problem

Children with learning disabilities are 28 times more likely to have a serious sight problem than other children (SeeAbility).

Eye care delivered in hospital or clinical settings for children with learning difficulties:

- is challenging for the child, their family and clinicians;
- is delivered in an unfamiliar and unsuitable environment for the child;
- takes a number of visits to achieve a full assessment and eye examination;
- has high non-attendance tor cancellation rates;
- leads to delayed diagnosis and treatment.

This transformation addressed the unmet need for all children in special schools to access high quality eye care to provide the right care at the right time in the right place. Working positively with commissioners established cost savings, improved efficiently and integrated working allowing all professionals to work together in school for the benefit of the child or young person.

Orthoptists employed by Warrington and Halton Hospitals NHS Foundation Trust (WHHFT) provide services across both acute and community sectors and work within the eye care team and a number of wider multi professional health and educational teams.

Aims and Objective

1. To provide equitable access to orthoptic led eye care to all children attending special school in the Warrington, Widnes and Runcorn area.
2. All assessments to be carried out in school, including joint assessment with the eye care team and teachers for the visually impaired when necessary.

Method and approach

Orthoptists were positively welcomed into each school, provided additional vision training for teachers, parents and others, a specialist orthoptist named for each school and regular visits allowed the children to see the orthoptist as part of the school team. Parental support for the service was very high and subsequent feedback was excellent. Effectiveness measured by regular audit of the visual intervention and outcomes and parental and teacher experience. Teachers share improvement in educational achievements related to the orthoptic and eye care team's interventions.

Results and evaluation

- Over 60% of children in our special schools had a visual anomaly identified and treated.
- All children and young people seen in school.
- Transition arrangements to adult services are now in place.
- More children per session seen in school than in a hospital clinic.
- Appropriate tariff arrangements agreed - more cost effective in school.
- 95% of parents prefer orthoptic led eye service in school.
- 90% rated service excellent or very good.

"We have to wait in the hospital which is stressful - and school is a safer / known environment".

"My child suffers with anxiety when at a hospital and treatment may be unsuccessful".

"This is an excellent service with excellent professionals - well done!".

"This is a good service that takes away a stress from an already stressed parent something I don't have to worry about".

"Amazing service done at school please don't change it - too distressing for child and parent.

Having my child's eye care provided in school is brilliant and trying the same tests in hospital would cause melt downs. I am very impressed with the service".

Key learning points

- Direct discussion and engagement with commissioners was key.
- Supplementary messages to parents and teachers about eye care were essential for their support.
- Appropriately trained specialist orthoptists with advanced skills and knowledge to assess children with special needs.

Plans for Spread

- Shared outcomes with SeeAbility (eye sector charity) and involved as key stakeholder with their campaign for every child in special school to receive eye care in school.
- To share knowledge where these services exist to increase awareness and outcome data.

Key Contacts

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Case Study 46:
Sport for Confidence.

Understanding the problem

Originally a partnership between the Occupational Therapy Learning Disability Service (South Essex Partnership University NHS Trust) and Everyone Active (Leisure provider) at Basildon Sporting Village. Sport for Confidence is now a social enterprise. It is jointly founded and led by a learning disability occupational therapist and a learning and development professional.

The definition, principles and values of Sport for Confidence are:

1. Support leisure centres and other mainstream sports groups and venues to deliver the reasonable adjustments they need in order that people with learning disabilities, Asperger's syndrome, mental health difficulties.

2. Develop a community within such centres that provides an appropriate activity environment in which learning disabilities professionals can assess and deliver therapeutic interventions for individuals through physical activity and sport.

3. Mentor, train and support coaches to adapt their behaviours and professional practice to become more inclusive, accessible and client focused.

Research shows that people with a learning disability remain one of the most excluded groups in sports and not only are participation rates low, but they are falling. Sport for Confidence encourages people with and without learning disabilities to participate together. This approach is also championed by Special Olympics through their Unified Sports®' programme which was inspired by the principle that 'playing together is a quick path to friendship and understanding'.

Aims and Objective

To facilitate access to community sport and leisure facilities, increasing social and community inclusion and participation in fitness orientated activities.

- Provide opportunities for individuals to achieve personal objectives through participation in purposeful activity; heightening awareness of self and health issues; and promoting physical and mental wellbeing.

- Provide opportunities for individuals to develop their social communication and interaction skills.

- Participants are encouraged to take leadership courses and Level 1 coaching qualifications and play an active leadership role within many of the groups.

Method and approach

The role of occupational therapy (OT) in the programme is to contribute specialist knowledge and work closely with the leisure centre staff, coaches and community learning disabilities teams to ensure that the needs of the clients are met and that there is regular communication, reflection and mentoring support.

There are now over eight sessions delivered per week (trampolining, multi sports, cricket, boccia, New Age Kurling, athletics, parkour, netball, tennis and fencing). The group is comprised of both men and women aged between 16-55.

Results and evaluation

Feedback information was gathered from clients and carers in the form of questionnaires, interviews and group discussions:

- 100% of clients identified that attending Sport for Confidence had given them the opportunity to be more active and try new things and the vast majority identified that their health and wellbeing and confidence had improved.

- 100% of carers reported seeing the confidence of their supported individual improve and the same percentage claimed that the Sport for Confidence group had improved their individual's opportunity to meet new people and make friends.

- 65% of clients have gone on to join other local clubs, sports and activities since attending SFC.

Return on investment:

There is a customer charge of £2.20 to attend each session.

Costs of providing the service for one year in one setting/area = £25,000 per area.

For (300 x 12) = 3,600 unique visits per year = £6.94 cost per visit.

Less the customer charge of £2.20 = £4.74 per visit.

NICE public health guidance on the management of long-term sickness and incapacity for work provides cost information on workplace physical activity intervention involving 10 sessions of physiotherapy/ physical activity and 10 sessions of cognitive behaviour therapy gives a total cost of £860 for the total 20 sessions.

= £43 per session.

Key learning points

A partnership between clients, families/ carers, occupational therapy, community nursing, coaches and leisure centre staff to provide a holistic approach to increasing confidence for individuals in accessing the local community, developing independence and achieving goals. It is also important that the coaches and leisure providers signpost and contribute to the planning of new sessions as their knowledge of sport, equipment and resources, local mainstream clubs, volunteering opportunities and training are all key to ensuring there are opportunities for progression.

Plans for Spread

The service has received funding to expand to other leisure centres in Essex.

The case study has been shared with the College of Occupational Therapists for Occupational Therapy: Improving Lives, Saving Money Campaign.

Key Contacts

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Case Study 47:
Art Therapy in cultural spaces.

Understanding the problem

Art therapy has been an important part of learning disabilities (LD) inpatient mental health services.

To address issues raised within the national programme of transforming care Simon Critchley has been working on a pilot project in the community, with the aim of providing alternative person centred early interventions to those individuals assessed as showing an increasing risk of hospital admission.

It is recognised that there is historically a limited range of therapeutic interventions available to people with learning disabilities at the point of crisis in the community, especially those with limited verbal communication skills. Nationally and regionally art therapy is not always provided to community based learning disabled mental health service users. A small pilot project has been carried out in Newcastle to look at the engagement, acceptability, and naturalistic outcomes for people accessing art therapy in the community. Within this pilot project art therapy has been shown to be beneficial in helping service users avoid distressing and disruptive admissions to hospital inpatient wards, allowing them to maintain positive mental health and continue to establish a sense of purpose and rewarding lives in their communities. The art therapy approach being used also includes involvement with support networks, including family members and/or support workers.

It is also acknowledged that people with learning disabilities can become easily isolated once clinical mental health services cease to provide input, and adults with learning disabilities find it hard to become actively involved in inclusive social activities in the community. This isolation can lead to relapse and repeated deterioration in mental health and can contribute to the "revolving doors" syndrome of repeat hospital admissions.

Aims and Objective

The aim of the project is to help prevent/reduce the frequency of admissions at the point of crisis to inpatient beds which are now becoming less readily available, and to help prevent deterioration in mental health for people with learning disabilities by reducing the sense of social isolation post discharge from clinical mental health services. To support this aim the project has been trying to bridge the gap between clinical art therapy interventions and arts in health provision in the community encouraging a more effective transition from clinical input to social community activities.

This work has recently been consolidated and celebrated with a group project with BALTIC Centre for Contemporary Art, Gateshead in which people with learning disabilities and a history of mental health difficulties who have previously received art therapy input in the community worked together with a resident artist and art therapists to explore the concept of mental health and dignity alongside the benefits of engagement in cultural creative spaces - culminating in an exhibition and film premiere in the BALTIC on World Mental Health Day 2015.

Method and approach

The approach involved working with previously identified at risk adult learning disabled mental health service users offering one to one short term (twelve or more planned sessions), directive and solution focussed art therapy interventions at the point of crisis.

Weekly art therapy sessions were offered and after a brief assessment period personal goals for therapy were identified with service users identifying up to three things they were struggling with at the point of crisis, which were then explored in therapy. Other information about the individuals was explored using person centred planning techniques (such as social network maps) and these were used to identify the social support that each individual received and whether they found this social structure helpful or unhelpful.

Anger, stress and anxiety levels were also rated on a weekly basis as this encouraged communication about other difficulties being experienced at the time of intervention.

Close communication with support services and families was also maintained during therapy so that the work done in sessions could be further supported on a daily basis by staff/families involved in the individuals' care on a regular basis. In this way issues contributing to the marked deterioration in mental health could be more effectively resolved.

Working alongside arts in health projects in the community to foster links between community services up to and beyond the point of discharge with the aim of establishing community support structures around individuals at the end of therapy was explored and pursued. In addition the art therapy service recently linked up with the BALTIC Centre for Contemporary Art to run a group project with adult learning disabled people in recovery from mental health difficulties as follow up work up to 6-12 months post therapy to further support and consolidate successful integration into cultural community activities and to help develop their confidence in engaging in public cultural spaces and to develop a sense of purpose and sense of belonging in the communities in which these often marginalised individuals live.

At this project a group of people with learning disabilities were given the opportunity to work alongside BALTIC Resident Artist Lesley-Ann Rose and Art Therapist Simon Critchley on a six week project inspired by Fiona Tan's DEPOT exhibition.

This project was partially funded by charitable grants from community initiatives Launchpad and The Chrysalis Fund, with NHS staff costs being met by NHS budgets and venue and materials costs met by the BALTIC.

Results and evaluation

Quantitative outcome measures completed pre, during and post individual therapy, gathered from a cohort of 15 of the 40 individuals offered therapy have shown that mental health can be supported prior to hospital admission with changes in scores evidencing significant improvements in mental health measured on the HONOS-LD (Health Of the Nation Outcome Scales for Learning Disabilities) scale and significantly reduced levels of anxiety reported by service users on the GAS-LD (Glasgow Anxiety Scale). Other measures which have shown some improvement include Quality of Life questionnaires and Glasgow Depression Scale (GDS-LD) alongside personal goals identified at the point of referral.

This work goes some way to supporting a reduction in hospital admissions with less than 10% of 40 people being offered art therapy at the point of crisis needing eventual admission to an inpatient ward. This in the long term will also contribute to cost savings for NHS services in adult LD mental health.

The BALTIC ANIMATE project was successful in engaging nine individuals (six female, three male) over the six week period, of which three were inpatients (previously seen for art therapy in the community) and six were outpatients currently living in the community.

The benefits of the gallery space as an inspirational creative therapeutic environment (in an era when the traditional art therapy space is less of a reality) and as a vehicle for exhibition (building confidence and self-esteem of those involved) and educational purposes (for the general public) around mental health issues was addressed.

Over the course of six weeks the group had the chance to work within a fantastic creative space and experienced using a variety of media that they have never worked with before over six lively afternoons, including:

- A tour of the BALTIC Centre for Contemporary Art including Fiona Tan's DEPOT exhibition.
- Clay model making and sculpture.
- Art making with a variety of media.
- Stop frame animation and digital media recording and editing.
- Silk screen printing and poster making.
- Musical performance and recording.

The BALTIC Project allowed the attendees to be part of a social group in which they were able to develop skills and techniques and had an opportunity to continue to use art to help work towards better mental health. The work culminated in a short animated film produced by the group and screened within the BALTIC on World Mental Health Day 2015 which also served as an AIR (Audio Image Recording) illustrating the aims and benefits of the work.

Follow up group projects and activities can be perceived to support and consolidate mental health recovery by reducing social isolation, with individuals engaging well in the activities offered and providing qualitative feedback that they had:

- enjoyed the activities on offer,
- gained confidence from them,
- learned new skills,
- enjoyed the social atmosphere in the groups, and
- and also commenting that they would like to be able to access similar activities again in the future.

Key learning points

Positive points:

It is clear from this work that interventions more suited to individuals' needs and capabilities can be beneficial in maintaining positive mental health in the community, and if these are offered at an early enough point in mental health crises then hospital admissions can be reduced for this client group.

It is also clear that close collaboration with community support services and community activities can enhance the wellbeing of the individuals as they interact with their environment and social group - contributing to a reduction in social isolation and anxiety about managing difficulties in their lives.

Follow up work post discharge can also contribute to sustained mental health in a client group that historically can experience repeated deterioration in mental health as a result of a lack of community opportunities and social difficulties and isolation.

The celebratory event at BALTIC provided validation of the group's capabilities (rather than their difficulties and the negative aspects of their lives) and also highlighted their need for recognition and acceptance in society.

It also clearly had a positive impact on individuals' self-esteem and confidence.

The animation and film produced and screened at the BALTIC included voice recordings from individuals in the group discussing mental health and the theme of "Dignity" (World Mental Health Day 2015's theme), making the film a collaborative Audio Image Recording (AIR) but also an educational / awareness raising piece if viewed by the general public.

The individuals involved in the project also experienced something they never thought possible: having their animation screened at BALTIC and their artwork and music exhibited. The premiere event was a huge success and the attendees, staff and invited family members were thrilled by the film screening and chance to show off their work with 25 people attending in total on the evening.

Further learning:

At times difficulties enabling individuals to access ongoing support were noted.

These could be explained by problems with people with learning disabilities sometimes not receiving adequate or flexible enough community/familial support to allow them to access the services on offer in the community. Also issues with limitations in finances were noted to be a predominant factor preventing this client group from being able to maintain involvement in community groups and social activities.

Some of these difficulties were addressed more successfully at the point of the BALTIC ANIMATE project, as thanks to the charitable funding provided by community initiatives, transport was provided and some travel costs were met for individuals and their support staff to attend the groups. This enabled more individuals to engage in this activity than had been achieved in previously offered social activities/groups.

However this was a short term group running over six afternoons and it would be difficult to maintain this level of cost over a longer period of time without additional finances being factored more permanently into peoples' personal budgets to meet such needs.

The long term implications of such a shift in thinking around finances could far outweigh the costs of hospital inpatient admissions, ongoing/repeated mental health service costs and additional expenses incurred on social services due to disruptions in placements and community support team employment if the costs of social community activities could be better supported financially for this vulnerable client group.

Plans for Spread

The work produced with the BALTIC was exhibited and presented at BALTIC on World Mental Health Day 2015 at a celebratory event and is archived in BALTIC's catalogue of films.

The work done in the BALTIC ANIMATE project has also been presented at a British Association of Art Therapists Museums and Galleries Special Interest Group meeting and at the "Finding Spaces, Making Places" Art Therapy Conference at Goldsmiths University, London, receiving positive feedback and recognition in highlighting the therapeutic benefits of utilising cultural spaces in art therapy provision.

Key Contacts

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Simon Hackett, Learning Disabilities (LD) North of Tyne Arts Therapies team leader, Northumberland Tyne and Wear NHS Trust.

Sarah Bradbury, BALTIC Centre for Contemporary Art, Tyne and Wear.

Case Study 48:
Introducing registered ward-based therapists to improve care and quality and lessen the impact of registered nurse vacancies.

https://improvement.nhs.uk/uploads/documents/Case_study_-_E_Lancs.pdf

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Case Study 49:
Improving patient experience by reducing therapy interventions using integrated therapy roles.

https://improvement.nhs.uk/uploads/documents/Case_study_-_N_Midlands.pdf

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Case Study 50:
Re-designing multidisciplinary ward teams across inpatient mental health services.

https://improvement.nhs.uk/uploads/documents/Case_study_-_South_Staffs.pdf

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Case Study 51:
Advanced Practice reporting radiographers.

http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/Marketing/201516%20Project%20Cards/21602RadiologyFinal.pdf

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Case Study 52:
Utilising radiography skill mix to increase imaging capacity and capability.

Understanding the problem

Mid Yorkshire Hospitals is a large multicentre acute NHS trust incorporating Pinderfields (Wakefield), Pontefract and Dewsbury Hospitals. It provides a full range of secondary care services and tertiary burns and spinal injuries rehabilitation services.

The driver for change was increased imaging referrals, particularly in CT and MRI, combined with a drive to decrease waiting times which placed pressure on the radiology department. The number of radiologists and radiographers was limited and so a different way of staffing the department was required.

Aims and Objective

Aim:

- To introduce a robust workforce plan utilising skill mix to enable radiographers to take on a greater range of roles and delegate activities to assistant practitioners. Radiographers have taken on the reporting of Xrays, CT and ultrasound scans, they are also performing screening procedures and sigmoidoscopy.

Objectives:

- To deliver increased capacity for procedures and reporting.

- To establish new patient pathways.

- To improve career progression and job satisfaction.

Method and approach

We developed a trainee consultant radiographer programme to support five aspiring AHP consultants.[1,2] They established workforce plans and supported implementation of a fully skill mixed department. Patient pathway mapping provided opportunities to streamline the journey and implement new ways of working.

Results and evaluation

Radiographers now report over 70% of the x-ray examinations, this amounted to 140,517 x-rays in 2015 and five assistant practitioners support the backfill of the advanced practitioners. The advanced practitioners provide immediate reporting, this has been shown to reduce health economy costs by £23 per patient as well as reducing risk and improving clinician confidence.[3,4] Radiographers also can discharge ED patients directly with normal findings, reducing patient waits and improving satisfaction.[5] They also support the nasogastic tube service by reporting and managing misplaced tubes.[6,7]

Similar activities occur in other imaging modalities, with ambulatory care pathways to provide rapid access whilst reducing bed use. Radiographers produce the majority of the CT head reporting and are a core member of the multidisciplinary team. In fluoroscopy radiographer-led procedures are common, including hystrosalpingograms, GI studies and proctograms.

Introducing new roles was challenging at an individual level but peer support has enabled the team to deliver beyond expectation.[1,2]

Key learning points

- Be clear about the objectives and communicate widely.

- Set clear objectives and expectations.

- Do not be bound by current scope of practice.

- Measure the impact of changes.

Plans for Spread

The scope and expectations of the trainee consultant role has been shared with a number of organisations who have (or are intending to) implement similar roles.

Key Contacts

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Lisa Field, Consultant Radiographer, Radiology, Mid Yorkshire Hospitals NHS Trust.
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1   Hardy M, Nightingale J. Paper 1: Conceptualizing the Transition from Advanced to Consultant Practitioner: Career Promotion or Significant Life Event? Journal of Medical Imaging and Radiation Sciences 2014; 46: 356-64.

2   Hardy M, Nightingale J. Paper 2: Conceptualizing the Transition from Advanced to Consultant Practitioner: Role Clarity, Self-perception, and Adjustment. Journal of Medical Imaging and Radiation Science 2014; 46: 365-72

3   Hardy M, Hutton J, Snaith B. Is a radiographer led immediate reporting service for emergency department referrals cost effective? Radiography 2013; 19: 23-7.

4   Snaith B, Hardy M. The perceived impact of an emergency department immediate reporting service: An exploratory survey. Radiography 2013: 19: 92-6.

5   Snaith BA. Radiographer discharge in A&E: the results of a pilot project. Radiography 2007; 13: 13-7.

6   Snaith B, Flintham K. Radiology responsibilities post NPSA guidelines for nasogastric tubes: A single centre review. Radiography 2015; 21: 11-5.

7   Snaith B, Milner RC, Harris M. Beyond image interpretation: capturing the impact of advanced practitioner radiographers. Radiography 2016; 22: e233-e38.

Case Study 53:
Improving efficiency and patient experience through effective job planning.

Understanding the problem

Doncaster and Bassetlaw Hospitals NHS Foundation Trust provide a wide range of health services to a population of around 420,000 on our three hospitals (Bassetlaw Hospital, Doncaster Royal Infirmary, and Montagu Hospital,) and community locations including Retford Hospital and Chequer Road Clinic. In 2015/16 we had a turnover of £360.0m and 170,150 people attended our hospitals for emergency care, 63,825 of whom were admitted to a ward. We treated 52,287 patients as planned day cases, 11,847 patients having planned inpatient care, and 539,023 outpatients (including maternity but excluding clinical therapies). Therapy service includes physiotherapy, occupational therapy, nutrition and dietetics, speech and language therapy, orthotics and podiatric surgery employing 300 WTE staff.

- Long waits and increasing demands across physiotherapy, occupational therapy, speech and language therapy and dietetics. On examination inequity of appointment numbers, appointment type including new patient: follow up ratios and appointment length were identified in similar services over different teams / sites.
- A number of services utilised a large amount of non-specific appointment slots - leading to gaps in dairies.
- Inequality in the amount of non-clinical time within staff grades and teams.
- Job plans have been used in some outpatient therapy services for several years but required robust review.

Aims and Objective

Aim:

For all staff to have an accurate and up to date job plan.

Objectives:

- to maximise clinical time, applying lean methodology, using the existing resource in a more efficient way, based on agreed new patient to follow ratios, with appointment types and length based on agreed patient need.
- reviewing non-clinical (supporting professional activities) utilisation to maximise input.
- engaging all staff and being transparent in the process of job planning to and embed into standard working practice and empowering staff to 'own their own' job plan.

Method and approach

- Mapping current treatment pathways, reviewing current waits and patient activities.
- Collaborative piece of work with management accountants to develop a productive hours analysis tool to ensure that a realistic assessment of clinical time available for overall productive hours and patient contact is established.
- Agree standardised slot length for specific patient pathways / services.
- Agree new to follow up appointment ratio for out-patient clinics / community.
- Agreed percentage of time allocated per staff grade for clinical duties and supportive clinical duties.
- Friendly challenge of existing practices and identifying new ways of working.
- Ensuring the lean methodology is used throughout.
- Internal and external peer review.
- Robust individual job plan agreed with regular review.
- All job plans replicated within electronic rotas i.e. SystmOne.

Results and evaluation

- All staff across services have up to date job plan based on their role and service need.
- Agreed inputs for therapy pathways, open to scrutiny and transparent.
- Clinical session appropriate to patients needs and delivering best outcomes.

Green	Safe Staffing	Unlikley risk to patient/ staff and service delivery expceted	There may be a requirement to cover other teams if required	Band 7 to escalate any specific caseload issues to site lead if required
Amber 1-2 consecutive days	Pressure to staffing	Possible risk to patient/ staff and service delivery expceted	Manageable in the short term	Band 7 to look at staffing around own site and ask around site teams if support needed. Otherwise manage within your own team but escalate to management if any specific caseload issues
Amber 3 days or more in a row	Significant pressure / unsafe staffing levels	Likley risk to patient/staff and service delivery expceted	Support needed from elsewhere	Band 7 to escalate with site lead who will look to allocate support from other speciality teams on site or request cover from other site leads if unable to cover on same site
Red	Unsafe staffing levels	Almost certain risk to patient/ staff and service delivery expceted	Support needed from elsewhere	Band 7 to escalate with site lead who will look to allocate support from other speciality teams on site or request cover from other site leads if unable to cover on same site

- Reduced waits for services, e.g:
  - Implementing job plans across two hospital sites for MSK outpatient clinics increased overall capacity by 36% on one site and 18% in another.
  - Community physiotherapy waits for routine appointments had increased to 12 weeks and within 3 months were reduced to 2 weeks following the implementation of job plans.
- Shifting of resources between sites / specialities to maximise capacity and equalising waits.
- Work completed will be invaluable to support the unbundled of the Clinical Therapy Block Contract with local CCGs this year.

Key learning points

- Staff engagement key to success.
- Team lead ownership of job planning process and making it part of 'business as usual'.

- Investing time in understanding and developing pathways.
- The job plan is intrinsically linked to capacity and demand assessment / skill mix and workforce review.

Plans for Spread

- Shared with the Trust executive team resulting in the methodology being used across non-ward based nursing.
- Recognised in the annual Trust Staff Awards for Service Improvement.
- Shared with local AHP networks.
- Shared with AHP Carter Workforce Efficiency workshops with the DoH.

Key Contacts

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Case Study 53:
Safe Staffing for Occupational Therapy.

Understanding the problem

Nationally there is a call to improve our understanding and consistency when planning for safe staffing in our teams.

As well as maintaining safety for our patients sound understanding of staffing is needed to ensure productivity and efficiency is maximised.

Whilst most of the national attention and direction has been about safe staffing levels within nursing, there is a push to apply the same level of attention on AHP services.

Locally the issues we faced included:
- Difficulties associated with cross site cover in a large organisation.
- Concerns regarding the consistency of allocating staff resources in line with clinical need as opposed to historical staffing levels.
- Forward planning of leave and cover to avoid crisis management.
- Staff awareness of pressures in the whole service.
- Ability to clinically reason staffing levels required for an existing service.

Aims and Objective

The initial aim of our project was to agree safe staffing levels within our team. To enable us to:
- Plan safe level of care.
- Manage safe levels of care on a day to day basis.
- Escalate concerns when safe staffing levels are not met.

Method and approach

It started with sharing of an annual leave planner from our physiotherapy colleagues, they had been using this tool to plan leave and cover for some time and it looked like it may help address some of the issues we were having as an occupational therapy team (OT).

When we started to develop the tool for OT services we realised that we were setting safe staffing levels on our "best guess" Discussion with colleagues in our own and local trusts and a read around the subject brought no better solution. So we went about devising a tool to aid this reasoning.

The tool wasn't anything new, it was putting down in writing what many people are doing informally when planning a service for the first time.

The basic principal was:

Clinical time needed for an average patient x the number of patients + an uplift to account for non-clinically related time = how much staff time you need to safely manage the needs of that patient group.

This is what it looks like for a simple, single patient pathway caseload.

For more complex teams we split up the patient pathways and add together to get a calculation for the whole team.

Once we have estimated the staffing level needed we input this into our annual leave calculator and agreed an escalation policy.

The non-clinical time uplift was set at 15% based on national benchmarking outcomes in 2015.

We have also added a 23% vacancy uplift (our trust value) to calculate WTE required in team to achieve the safe staffing level.

Results and evaluation

We have realised many benefits from implementing this safe staffing tool with our staff, some of which addressed the original issues and some were an added bonus we hadn't initially planned.

The tools have been developed and updated through joint working with local physiotherapy colleagues and also as part of a joint North West AHP project group looking at safe staffing tools.

- As the annual leave planning tool is visual and updated by the teams, the team leaders and wider teams have a much better understanding on service pressures as a whole.

  "The safe staffing/annual leave calendar has allowed us (site managers) to ascertain staffing levels across all sites, in both an emergency situation and in the day to day management of staffing. It has helped with the planning of holidays and staff feel that they are in control and are able to visualise when help is required on other sites."

- Planning leave and cover is done in advance with team leaders; we review regularly and avoid crisis management of shortages.

  "The safe staffing spreadsheet/annual leave calendar makes it easier for me as a team leader, to look at a glance when staff wish to book annual leave as to whether it is something we can support or whether we can approach other teams / sites for support to enable the team member to take the dates they want. The team are also able to take some responsibility themselves by looking at the safe staffing spreadsheet before requesting annual leave or TOIL. It is a lot easier to read than a calendar pinned to the wall.

  I can look forward over the next month and identify or begin to predict when we may be short staffed (ie. Amber or Red status) and then begin to initiate contingency plans."

- Safe staffing levels are reviewed monthly in relation to activity data already collated. This has resulted in some changes to our staffing allocations, with resources being reallocated in line with clinical need.

- We have used the calculator to estimate staffing requirements for business cases.

- We have used the calculator to compare staffing requirements pre and post service initiatives.

- We monitor service staffing levels on a monthly basis and use this data to escalate areas of concern and justify recruitment to vacancies.

Key learning points

This has very much been a learn as we go process and the tools are still being fine-tuned and amended as other teams pilot and share experiences.

The tools have also been used within:

- Physiotherapy at The Royal Oldham Hospital

- Occupational Therapy and Physiotherapy at Aintree Teaching Hospital

- Occupational Therapy and Physiotherapy at Southport Hospital

Joint working has brought great ideas and additions:

- Working with Aintree and Southport we were able to compare across localities. We were also able to compare between expected clinical need and actual clinical need calculated at Aintree (clinical contacts + unmet need). This enabled us to quality check our estimated figures and estimate with some degree of confidence that a typical acute medical patient pathway is around 2.5 - 3 hours for occupational therapy.

- Working with physiotherapy colleagues at Oldham has added in the need to incorporate time working as "doubles", when two clinicians are working with a patient.

- Working with other disciplines has highlighted that the safe staffing tool is not always needed to generate levels for the annual leave calendar. We use national guidance or service specifications to set safe staffing levels were available e.g. inpatient rehabilitation and stroke.

- Working with other disciplines has highlighted the need for the tool to be used for specific condition related pathways (e.g. weight management) as well as general caseload pathways (e.g. acute surgery).

Plans for Spread

Although the tools are useful on a local level, there is much work that needs to be done if they were to be reliable and validated for wider use. With many projects underway at national level we are cautious around progressing this without further developing links with other streams of work.

Currently the plan is:

1. Pilot tools across additional North West sites and include colleagues from dieticians and speech and language, to:

    - Investigate whether we can predict typical patient pathways in some areas with more data comparisons available.

    - Fine tune the tool to work for other professions.

    - Develop more examples of how these tools can be put into practice.

2. As a trust we are also hoping to work closely with our IT teams to develop these tools so they are more user friendly. This should also mean we can share with others more readily.

3. Physiotherapy teams at Pennine plan to develop the RAG rating escalation plan to communicate to wider teams service expectations e.g. what service can be expected on a red day.

4. As a North West AHP project group we are linking in with the work being undertaken by Rosalind Campbell in response to the Carter Report around operational productivity and unwarranted variation.

   We are hoping that this will provide further direction and also challenge the 15% uplift for non-clinical time. Although this is the number coming out of national benchmarking, anecdote and research would indicate that this number is likely to be higher.

5. The North West project group plan to review national reports, research and guidance to support further development. We have supported, as a critical friend, phase one and phase two of the national safe and effective staffing rpogramme which is now being led by NHS Improvement.

   National Quality Board (NQB) - Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time : Safe sustainable and productive staffing - July 2016.

Key Contacts

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Janet Mitchell, Physiotherapy site lead at The Royal Oldham Hospital.

Angela McAvoy, Clinical Business Manager, Therapies.

Caitlin Edwards,Clinical Therapy Manager Medicine, Surgery, Orthopaedics, Elective Surgery and Spinal Injuries, Southport and Ormskirk Hospitals.

"I think what we have collectively achieved here is nothing short of revolutionary actually the way that healthcare strategy is shaped".

Anon: 23 June 2016. Direct feedback from the audience at the Chief Allied Health Professions Officers Conference.

"I'm a qualitative researcher and listening to what you have done I just think that it sounds like a superb piece of work to me, it just sounds so valid, it sounds reliable, because you have got people's voices and you have gone out to so many people, it just sounds brilliant, so I am really looking forward to it being published in October, can't wait".

Anon: 23 June 2016. Direct feedback from the audience at the Chief Allied Health Professions Officers Conference.

'AHPs into Action' is a product for leaders and decision makers, to inform and inspire the system about how AHPs can be best utilised to support future health, care and wellbeing service delivery. It has been co-produced using data and evidence; a review of national policy documents and publications; engagement and involvement from senior leaders across the system. Over 16,000 contributions were submitted from patients, carers, the public, and health and care staff including AHPs, through a process of crowdsourced via an online platform and developed with the partner organisations that deliver and oversee health, care and wellbeing services including:

- NHS England
- Health Education England
- NHS Improvement
- Public Health England
- NHS Employers