Supporting older people to self-manage
Contents

Editorial by Sarah De Biase ............................................................... 1
National Executive Committee (NEC)/Regional Representatives’ contact details ................................................................. 2
Chair’s address: by Louise McGregor .............................................. 4
President’s address by Edith Macintosh .......................................... 5
Putting physical activity at the heart of self-management for people with arthritis by Kate Croxton, Michael Hurley and Benjamin Ellis ................................................................. 6
A pilot study to explore the benefits of a self-management and exercise programme for newly diagnosed people with Parkinson’s by Fiona Kay ................................................................. 11
A supporting self-care intervention for older people at risk of frailty by Gill Thornton and Sarah De Biase ................................................................. 15
Dutch Journal of Geriatric-Physiotherapy: translation of two articles (October 2016, Volume 30, No. 3) translated by Ed Bakker ...... 16
Research update: Complex interventions by Katie Robinson ......... 20
AGILE journal club: Promoting self-management and adherence with strength and balance training for older people with long-term conditions: a mixed methods study by Carley King and Sarah Seager ................................................................. 23
Can personalised activity plans reduce the amount of time hospitalised older people spend being inactive? A practice project by Gavin Snelson ................................................................. 26
Person centred pathway of care for mental health services for older people physiotherapy – functional clip by Chris Potts .................. 30
Effective use of music to facilitate therapeutic engagement and self-management in older adults by Kolapo Jegede ......................... 35
AGILE National Study Days 2017 .................................................... 38
Using benchmarking data to improve clinical practice and service provision in services for older people by Alison Cowley and Louise Bramley ................................................................. 40
The organisation of physiotherapy services on acute Care of the Elderly wards in Scotland. Mapping models of service delivery by Joke Delvaux ................................................................. 44
National Back Exchange by Carol Hucknall .................................. 49

Editorial

Author: Sarah De Biase – Agility Editor

The resources required to manage frailty and other long-term conditions (LTCs) are enormous - treatment associated with LTC accounts for 70% of NHS health and care spend and older people with frailty are majority users of health and social care services (BGS 2014). However, despite evidence of effect in older people from supported self-management for long-term conditions, interventions which help older people to develop the knowledge and skills needed to manage their own health and well-being are few. But as recommended in the NHS England (2014) Five Year Forward View, health and care providers are beginning to realise that the sustainability of the NHS depends on a radical upgrade in prevention and public health.

There are 13 principal risk factors associated with increasing functional dependence in older people and the majority of these risk factors are potentially modifiable (Stuck et al 1999). It is these 13 risk factors and more that have been turned into healthy ageing recommendations in the NHS England and Age UK (2015) Practical Guide to Healthy Ageing https://www.england.nhs.uk/wp-content/uploads/2015/09/hlthy-ageing-brochr.pdf resource (see figure 1). Handing out this Practical Guide to older people is one simple step in the right direction to enabling better self-care and will help towards making ‘every contact count’.

As physiotherapists, we have a role in helping older people to modify their individual risk factors through targeted, individually tailored support to self-manage. This edition of Agility showcases some of the work being undertaken by AGILE members to help improve the self-care ability of people living with long-term conditions and/or multimorbidity. In both the Chair’s and President’s address on pages 4 & 5 respectively, we read about the link between supported self-management and person-centred care for older people. We hear how guided conversations with the older person at the centre will result in co-produced

Data Protection Act Members’ details are held on a computer database. Questionnaires may be sent by students undertaking dissertations – this will be via the membership secretary. The database address list may also be provided to a third party if the National Executive believe it would be beneficial to members’ interest in older people. Please write to the membership secretary if you do not want your details disclosed in either of these circumstances.

Copyright The material in this Journal is copyright to Agility and may not be published in another journal without the permission of the editor. Authors will be advised of any requests to reprint their articles in other journals. Opinions expressed in this Journal are not necessarily those of the Editor of Agility, AGILE or the publisher.
goals and actions which will enable the individual to live well for longer (and ultimately, live well until they die).

For those readers interested in developing and implementing self-management support interventions locally, there are many resources available to support this being done effectively, and with an underpinning evidence base. The Health Foundation’s (2015) Practical Guide to Self-Management Support provides an overview of evidence base and the key components for effective implementation. The King’s Fund (2014) Supporting people to manage their health: an introduction to patient activation describes a validated tool which can be used to measure activation levels in individuals using a self-report method. And the Realising the Value (2016) report on supporting self-management will help provide an understanding of the frameworks needed to really change behaviour, and gives real-world examples of how these changes happen in practice. I encourage you to read these resources and consider using the EAST model (Realising the Value, 2016) to put into action supporting self-management interventions so you too can increase the success of such interventions by making them: Easy, Attractive, Social and Timely for the older people.

Figure 1: Practical Guide to Healthy Ageing

In this edition of AGILITY, read about the ESCAPE Pain programme from Arthritis Research UK on page 6. ESCAPE Pain has been designed and tested with Arthritis Research UK funding to support people living with osteoarthritis to better manage their condition. The programme demonstrates impact at patient level in terms of quality of life and reduced pain; but also at service level through reduced recovery time after an operative procedure. Arthritis Research UK are eager to hear from AGILE members if they are interested in implementing the ESCAPE programme locally or if they have ideas about how the model can be implemented and spread. Read about a pilot self-management and exercise programme for people with newly diagnosed Parkinson’s on page 11. The physiotherapists involved have not been able to secure funding to continue delivery of this programme which is disappointing considering the outcomes suggest significant patient level benefit. As physiotherapists, we need to think about the sustainability of the interventions we offer (or pilot). Often this requires the ability to provide evidence of impact at service and system level (i.e. value for money) to funders/commissioners – to achieve this we need to become better skilled and trained in undertaking robust evaluations of the interventions we provide, and where possible include consideration of the health economic impact.

In this edition of AGILITY we are testing a new approach to include translations from the Dutch Journal of Geriatric-Physiotherapy. Two articles have been translated but in summary format for this edition on pages 16-17. On page 20, Katie Robinson focuses the research update on supported self-management as a complex intervention and draws us into the challenges faced when developing, understanding and evaluating self-management interventions in health research. These same challenges are faced during implementation as has been highlighted by our other authors. In the AGILE North journal review article on page 23, a mixed methods study design is critiqued which I understand proved to be quite a challenge. The study explores the effect of different strength and balance training interventions on self-management ability but application of the findings is restricted because of the very specific study population.

On page 26, Gavin Snelson’s pilot study highlights just how sedentary older in-patients are in hospital. Gavin describes work being undertaken at his Trust to reduce sedentary behaviours using personalised activity plans, which have been effective albeit to a small extent.

Read about a ‘Functional CLiP’ programme on page 30 - a 12 week programme aimed at improving physical fitness and wellbeing for older people using mental health services. The programme led to demonstrable improvements in the physical and mental health outcomes for participants, the follow up period was only for the duration of the programme; and so it is not clear if participant improvements were sustained beyond the length of the programme nor was there any consideration of return on investment which might support an argument for further funding to enable continued delivery and/or spread of the programme. On page 35, Kolapo Jegede describes his observations of older adults with mental health conditions as they embarked on music and dance sessions. The observations made alongside the qualitative feedback from other members of the therapy team, do suggest music has a place during therapeutic activity sessions for older people with mental health conditions particularly those with Dementia, but the study lacks rigour in terms of experimental design and so results cannot be generalised. The use of a validated measure such as Brooker et al’s (2007) SOFI tool (Short Observation Framework for Inspection) alongside more robust qualitative evaluation methods (for example, focus groups or interviews) and thematic analysis would have enabled the author to describe a much more credible observational study.

Although the next few articles are slightly off theme, they are worth including. Alison Cowley and Louise Bramley’s article on the NHS Benchmarking of Older People’s Care in Acute Settings is encouraging not least as it will help service users, providers and commissioners understand variation in the way health care is delivered for older people; draw out what is different about outliers and identify positive deviants, and initiate conversations and action to improve services. Following on from the NHS Benchmarking report, Joke Delvaux reports on a mapping exercise of physiotherapy service delivery models in acute care in Scotland. The article clearly articulates the variation in staffing levels across services both in terms of qualified physiotherapy staff ratios and support worker ratios. On page 49, is a piece from
the Chair of the National Back Exchange (NBE) aimed at introducing AGILE members to the network and inviting membership. The NBE aims to support the dissemination and promotion of evidence based practice in all aspects of moving and handling.

As I sign off, I would like to take this opportunity to thank Gail McMillian for her extended service to AGILE and for committed representation of our Northern Irish members. Gail hands over her Northern Ireland representative role to Martina McGovern.

The next edition of AGILITY is as usual planned for Autumn/Winter 2017. The theme will be managing long-term conditions to complement the theme of our 2017 National Learning Event, hosted by the East Region - I expect the supported self-management thread will be carried forth. Please consider writing an article or short report for inclusion in the next edition. The guidelines for authors are on page 3. Initial articles of interest/draft reports need to be submitted to the editor at agilejournal@gmail.com by the end of September 2017. Till then…

References

British Geriatrics Society (2014) Fit for Frailty

AGILE National Executive Officers

<table>
<thead>
<tr>
<th>OFFICER</th>
<th>NAME</th>
<th>EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESIDENT</td>
<td>Edith Macintosh</td>
<td><a href="mailto:agilehonpres@gmail.com">agilehonpres@gmail.com</a></td>
</tr>
<tr>
<td>CHAIR</td>
<td>Louise McGregor</td>
<td><a href="mailto:agile.physiotherapy.chair@gmail.com">agile.physiotherapy.chair@gmail.com</a></td>
</tr>
<tr>
<td>VICE CHAIR</td>
<td>Kate Bennett</td>
<td><a href="mailto:agile.vicechair@gmail.com">agile.vicechair@gmail.com</a></td>
</tr>
<tr>
<td>SECRETARY</td>
<td>Orlaith Talty</td>
<td><a href="mailto:agile.notessecretary@gmail.com">agile.notessecretary@gmail.com</a></td>
</tr>
<tr>
<td>MEMBERSHIP SECRETARY</td>
<td>Martina McGovern</td>
<td><a href="mailto:agile.membership@gmail.com">agile.membership@gmail.com</a></td>
</tr>
<tr>
<td>TREASURER</td>
<td>Vicky Paynter</td>
<td><a href="mailto:agiletreasurer@gmail.com">agiletreasurer@gmail.com</a></td>
</tr>
<tr>
<td>PUBLIC RELATION OFFICER</td>
<td>VACANT</td>
<td><a href="mailto:agile.pro.nec@gmail.com">agile.pro.nec@gmail.com</a></td>
</tr>
<tr>
<td>JOURNAL EDITOR</td>
<td>Sarah De Biase</td>
<td><a href="mailto:agilejournal@gmail.com">agilejournal@gmail.com</a></td>
</tr>
<tr>
<td>RESEARCH OFFICER</td>
<td>Katie Robinson</td>
<td><a href="mailto:researchagile@gmail.com">researchagile@gmail.com</a></td>
</tr>
<tr>
<td>WEBSITE OFFICER</td>
<td>Laura Cook</td>
<td><a href="mailto:agile.website@outlook.com">agile.website@outlook.com</a></td>
</tr>
<tr>
<td>EDUCATION OFFICER</td>
<td>Julie George</td>
<td>agile.education <a href="mailto:officer@gmail.com">officer@gmail.com</a></td>
</tr>
<tr>
<td>COMMUNITY OFFICER</td>
<td>Claire Goldsmith</td>
<td><a href="mailto:agile.community.officer@gmail.com">agile.community.officer@gmail.com</a></td>
</tr>
</tbody>
</table>

AGILE Regional Representatives

<table>
<thead>
<tr>
<th>REGION</th>
<th>NAME</th>
<th>EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAST</td>
<td>Laura Cook</td>
<td><a href="mailto:agileeast@gmail.com">agileeast@gmail.com</a></td>
</tr>
<tr>
<td>NORTH</td>
<td>Lynn Sutcliffe</td>
<td><a href="mailto:agilenorthrep@gmail.com">agilenorthrep@gmail.com</a></td>
</tr>
<tr>
<td>NORTH CO-REP</td>
<td>Sarah De Biase</td>
<td><a href="mailto:agilenorthrep@gmail.com">agilenorthrep@gmail.com</a></td>
</tr>
<tr>
<td>NORTHERN IRELAND</td>
<td>Martina McGovern</td>
<td><a href="mailto:agilenorthernireland@gmail.com">agilenorthernireland@gmail.com</a></td>
</tr>
<tr>
<td>SCOTLAND</td>
<td>David Hegarty</td>
<td><a href="mailto:aglescottishrep@gmail.com">aglescottishrep@gmail.com</a></td>
</tr>
<tr>
<td>WEST</td>
<td>Kate Bennett</td>
<td><a href="mailto:agile.rep.west@gmail.com">agile.rep.west@gmail.com</a></td>
</tr>
<tr>
<td>WALES</td>
<td>VACANT</td>
<td><a href="mailto:agile.wales.region@gmail.com">agile.wales.region@gmail.com</a></td>
</tr>
</tbody>
</table>
Guidelines for Authors: Agility

Thank you for considering contributing to Agility.

Please submit the article via email as an attachment to the editor: agilejournal@gmail.com and include an email address for correspondence purposes.

The following guidelines should be considered:

• References, where appropriate, should be in the Harvard style
• In the text – one surname followed by date of publication (Jones et al 2003)
• In the reference lists – for journals: names and initials of all authors, title of article, full name of journal, volume number, issue number and first and last page numbers. For books: names and initials of all authors, followed by year of publication, title, place of publication and chapter or page numbers or both
• Articles should be about 2,000 words long. Reports should be as short as possible (usually not more than one page when printed in Arial, 10 point, on A4 size paper). However, exceptions can be made accordingly and at the editor’s discretion.

AUTHORS PLEASE NOTE:
Manuscripts should be in the English language.
Submissions will be acknowledged.
Material published becomes copyright to AGILE. Authors will be advised of any requests to reprint their articles in other journals.
Author’s name will be published; however, professional or academic qualifications are not usually indicated. Post titles may sometimes be relevant.
Reports and articles for inclusion in the journal should reach the editor by the deadline for submissions.
Deadlines for submissions are usually 6-8 weeks prior to the journal being posted to members.
Articles should, if possible, be submitted well in advance of the deadline. Authors should bear in mind that editing and reviewing takes time. For this reason, inclusion in the next issue cannot be guaranteed.

The deadline for an article or report for the Autumn/Winter 2017 issue is 29th September 2017.
Chair’s Address

Author: Louise McGregor – Chair of AGILE

As an older person’s physical health and/or psychosocial complexity increases and long-term conditions develop, the need for effective self-management skills and knowledge becomes essential. Many of our patients have multi-morbidity defined as “the presence of two or more long-term conditions” which can be:

- Defined physical and mental health conditions such as diabetes, COPD, cardiac failure and depression
- On-going conditions such as learning disability
- Syndromes such as frailty and chronic pain
- Sensory impairment such as visual or hearing loss
- Alcohol misuse

NICE has recently published new guidance on Multi-morbidity: Clinical Assessment and Management (NG56, 2016) which provides recommendations on the approach to care that takes account of multi-morbidity. The emphasis is on patient-centred care and the importance of establishing the individual’s preferences, values and priorities.

So what do we mean by self-management and how can we best empower our patients to have choice and control over their own health and wellbeing for as long as possible? Self-management support can be viewed in two ways: as a range of techniques and tools to help individuals to manage their own health condition on a day to day basis; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership (de Silva 2011).

As physiotherapists, we are ideally placed to promote self-management through goal setting, motivational interviewing, multidisciplinary and multi-agency working across the interface to name but a few.

This year’s learning event in London, October 2017 will focus on self-management strategies in long-term conditions. I look forward to seeing you there!
President’s Address: Self-management – giving people back the power - do we?

Author: Edith Macintosh - President

Over the last few years I have been working with a focus on improvement in the care sector. During this time I have given a lot of thought to what person-centred care really is and in turn how that fits with self-management.

AHPs have all the skills required to empower people to self-manage and to experience well-being, giving choice and control to a person, helping to build resilience in those they support. BUT do we? It may be a bit controversial but I wonder if in the busyness of our working day we take the time to truly find out what people’s hopes and dreams are - what they want to achieve, how they want to contribute to life and have a purpose. People often have such complex and challenging lives medically, psychologically and socially but we can enable them to find a way through that using our skills.

I love Atul Gawade’s quote in his book Being Mortal when he says;

“You may not control life’s circumstances, but getting to be the author of your life means getting to control what you do with them.”

I was recently involved in a series of workshops on ‘good conversations’. The purpose was to understand and develop skills to enable a focus on personal outcomes and asset based approaches. These skills are essential for supporting a self-management approach in relation to assessment, rehabilitation and being able to offer appropriate person-centred support. I felt it was a bit of a wakeup call for me and many others in the room, most of whom were AHPs!

I felt it was a bit controversial but I wonder if in the busyness of our working day we take the time to truly find out what people’s hopes and dreams are - what they want to achieve, how they want to contribute to life and have a purpose. People often have such complex and challenging lives medically, psychologically and socially but we can enable them to find a way through that using our skills.

One of the approaches I have been trying to promote in the care sector is to have a strengths-based focus with people using services instead of focusing on what people may not achieve or have the potential for. In terms of self-management I see this as one of the keys to success.

These are just some thoughts to hopefully help you to start reflecting on your practice in the context of supporting self-management. Here are some links you may also find useful. If you are not doing it already you go and start having those ‘good conversations’

Talking Points personal outcomes approach:

Good conversations:

Wagner’s chronic care model:
Putting physical activity at the heart of self-management for people with arthritis

Authors: Kate Croxton1; Michael V Hurley2; Benjamin M Ellis3.

1Head of Professional Engagement, Arthritis Research UK; 2Professor of Rehabilitation Sciences, St George’s University of London and Clinical Director, Musculoskeletal Programme, Health Innovation Network; 3Consultant Rheumatologist, Imperial College Healthcare NHS Trust and Senior Clinical Policy Adviser, Arthritis Research UK.

1.0 The impact of arthritis

“Arthritis doesn’t kill you, but it stops you living.” These words were spoken by a person affected by severe osteoarthritis. Osteoarthritis is the most common form of joint disease, and one of the leading causes of pain and disability worldwide, and more than 8.5 million people in the UK alone have sought treatment for this condition. With our ageing population, rising levels of obesity and low levels of physical activity this number is predicted to double by 2030. Collectively, musculoskeletal conditions account for the largest number of years lived with disability (YLD) in this country, and comprise the third largest England NHS programme budget £4.7 billion annual spend (Clark PM 2014).

Arthritis Research UK is now building on its history of funding musculoskeletal research and has committed to making a tangible difference to the quality of life of people who are living with the pain and disability of arthritis today. The top things people with arthritis have told us they want are:

• To reduce pain – this is number one thing people say would have a significant positive impact on their quality of life.
• To get information and advice that’s personal and relevant to them, that they can access in the way that suits them/their lifestyle.
• To connect to people with arthritis to share experiences and practical help and experience.

2.0 The benefits of physical activity for people with arthritis

For those living with arthritis or back pain, being physically active is one of the most important steps to take that will lead to reduced pain and improved mobility. These benefits have been characterised in several systematic reviews, and are reflected in national clinical and NICE guidelines (NICE 2014)

The benefits reach beyond people’s immediate musculoskeletal problems. Physical activity improves mental health and overall wellbeing, particularly when conducted in a group setting (Department of Health 2011) For the large number of people that have joint or back pain as part of multimorbidity, physical activity is important for cardiovascular, metabolic and respiratory health too. Regular physical activity is among the most important lifestyle factors for maintenance of good health at older ages (Hammer et al 2014) Inactivity in older populations has particularly detrimental effects on strength, flexibility, aerobic capacity, walking capacity, balance and mental and cognitive function. Therefore, combating inactivity, and associated health and function problems, is intrinsic to supporting healthy ageing.

Despite this, there are a number of reasons why people with painful musculoskeletal conditions may not be reaping these benefits. First, there is a national epidemic of physical inactivity, driven by social and cultural change, affecting everyone including those with these painful, long-term conditions. Second, persistent musculoskeletal pain, including osteoarthritis and back pain, disproportionately affects older and more deprived people, who may have less access to safe settings in which to be physically active, including parks and affordable indoor leisure facilities. Third, for people living with pain, stiffness and movement restriction it can be physically difficult to be physically active. Fourth, people with arthritis may have had previous bad experiences with exercise,
finding that it worsened their pain leading to fear and avoidance of future activity. Finally, many people have deeply held – and incorrect – beliefs that physical activity will increase the “wear” in their joints, and so mistakenly choose rest, rather than an increase in activity, to manage their symptoms.

High quality care for those with painful musculoskeletal conditions should support self-management, specifically enabling and encouraging people to be more physically active. Health and care systems must provide the support and advice people need throughout their journey, while making sure that appropriate facilities are available and accessible.

3.0 A new tiered, public health approach to physical activity provision (Arthritis Research UK 2016)

Providing physical activity interventions for people with musculoskeletal conditions, is a new report to support local commissioners and providers of health and wellbeing services including NHS and local authorities, to take action to improve musculoskeletal health locally (Ellis et al 2017) It was co-produced by Arthritis Research UK, the Department of Health, Public Health England and NHS England, and has been endorsed by the Chartered Society of Physiotherapy (CSP), Royal College of General Practitioners (RCGP) and the Local Government Association (LGA).

The report includes a review of the benefits of physical activity both for people with musculoskeletal conditions and wider society. At the heart of the report is a framework that supports a tiered approach (see Figure 1) to support people with these conditions to benefit from physical activity.

Many people can benefit from self-directed physical activity using accessible community facilities, so long as these are welcoming towards, and equipped for, the needs of people with musculoskeletal conditions. Others will benefit from supervised physical activity, including land- and water-based exercise groups, such as T’ai Chi, Pilates, walking groups or aqua aerobics. People with a higher level of need can benefit from taking part in structured community rehabilitation programmes, akin to cardiac or pulmonary rehabilitation. Finally, some will need individualised, hands-on support with prescribed exercises from physiotherapy.

“The ESCAPE-pain programme is an excellent example of evidence based supported self-management. It is a clinically effective and cost effective opportunity for physiotherapists to transform the lives of people with arthritis through education and empowerment.”

Steve Tolan, Head of Practice, Chartered Society of Physiotherapy.

To understand more about the available interventions, Arthritis Research UK commissioned a structured evidence review. For “tier 3” programmes, ESCAPE-pain emerged as having a strong evidence base for impact and value, improving quality of life for participants while saving the NHS money. ESCAPE-pain had previously been endorsed by the National Institute for Health and Care Excellence, British Society of Rheumatology and the Royal Society of Public Health.
4.0 Structured community rehabilitation programmes: ESCAPE-pain

Enabling Self-management and Coping with Arthritic Pain using Exercise (ESCAPE-pain) is a six-week programme of integrated exercise and self-management delivered in a group setting by a physiotherapist. As well as a tailored, progressive, exercise routine, patients learn about the causes of pain, how to understand their condition better, and to appreciate that exercise is a safe and effective self-management strategy, that can be used to reduce joint pain and the physical and psychosocial effects of joint pain (http://www.escape-pain.org/)

ESCAPE-pain was developed to be delivered by physiotherapists, traditionally in hospital outpatient departments. Work is now underway to deliver the programme by other fitness professionals in a range of community settings including leisure centres.

The programme is delivered to groups of between eight and ten people twice a week for six weeks, and includes two components:

1. An education component where people learn about their osteoarthritis, what might be causing it, why they experience pain, simple ways to cope and to self-manage.

   Classes start with a brief (20 minute) informal discussion around a set theme. This could include simple anatomy of the knee joint, what causes pain, goal setting, rest-activity cycling, weight management, healthy eating, and simple relaxation techniques.

2. An exercise regime where people undertake a progressive exercise programme tailored to individual needs and abilities.

   Classes include approximately 40 minutes of exercise, using simple, unsophisticated exercises that are easy to do. These include quadriceps exercises over a block, bending and straightening the knee, sit to stand from a chair, stepups, stepdowns, using a static bike, standing on a rocker board, standing on one leg, shuttlewalks, and squats. The exercises are progressive and self-paced, with programmes tailored to each person’s needs and abilities.

5.0 Evaluation shows that ESCAPE-pain:

- Reduced pain, improved physical function, reduced depression, and enhanced general well-being and quality of life (Hurley 2007a; Hurley 2012; Hurley 2010)
- Is more cost-effective than usual care (Hurley 2007b; Jessep 2009; Hurley 2012)
- May help delay or avoid surgery (Pisters 2007; Svege 2015).
- Promotes physical activity, reducing the risk of acquiring or exacerbating other conditions that people may have in addition to arthritis, such as diabetes and cardiovascular conditions.

6.0 Feedback from participants

“This has been a fabulous programme and I am so grateful to everyone. I am much more mobile... The exercises were new to me and have given me the confidence to continue with them for the rest of my life... A big thank you!”

“I have benefitted 100% from the class. My right knee is much improved and I have a training programme to help me with the rest of my life.”

“I learnt how to manage pain with exercise and the pain is much less now.”

7.0 Scaling up for impact

ESCAPE-pain was originated by Prof Mike Hurley with the support of an Arthritis Research UK Fellowship. Since 2013 the Health Innovation Network has led the implementation and development of the programme, and 31 different sites (predominantly in
the South East and London) have started to deliver the programme reaching more than 2,000 people. Many more could now benefit. The Health Innovation Network and Arthritis Research UK are working together to scale up the ESCAPE-pain programme so that more people with arthritis can have less pain and disability because they have taken part in, and sustained the benefits of the ESCAPE-pain programme.

8.0 Physical activity support – the role for physiotherapy

Educating and empowering people to self-manage is a fundamental ethos of physiotherapy. Physiotherapists innately understand and appreciate the pivotal role that physical activity plays in enabling individuals to succeed. Whilst physiotherapy spans a huge range of specialisms, care settings and patient demographics, holistic person-centred care sits at the heart of practice. Therefore, conversations about physical activity, and its importance to a person’s rehabilitation and ongoing health and wellbeing should be routine. Physiotherapists are ideally placed and skilled to have these discussions with patients; unpicking a person’s understanding and perceptions of physical activity, debunking myths and identifying barriers to participation.

Physiotherapists can motivate people by educating about the enormous holistic benefits of increasing activity levels, even more when supporting this with a tailored and agreed plan which speaks to the individual. Physiotherapists can use the tiered framework presented in this new report to help people explore their physical activity options, matching individual preferences along with an assessment of physical capabilities and comorbidity. This in turn requires a good working knowledge of local physical activity opportunities, providing specific information about accessing local services and facilities that meet people’s needs.

Physical activity should be everyone’s message. Physiotherapists can develop their role as ambassadors for physical activity within the multidisciplinary team, educating colleagues on the importance of physical activity promotion as an integral part of a person’s care and advocating for a systemic approach. Does the department have a plan or policy for physical activity promotion? Have local leisure providers, services and a range of physical activity opportunities been mapped out and connected with? Is this information readily available and accessible to patients?

On a broader scale, physiotherapists can be hugely influential in informing and shaping physical activity provision within the local area. One starting point for discussion could be asking key decision makers to read and comment on Providing physical activity interventions for people with musculoskeletal conditions (Arthritis Research UK 2016).

Arthritis Research UK wants to learn about examples of good practice in physical activity promotion and support. It might be that you have already identified the need for a specialist programme, like ESCAPE-Pain in your local area. You might have ideas for new interventions or already be delivering bespoke services that are working successfully for people with musculoskeletal conditions. If so we want to hear from you. Together we can put physical activity at the heart of self-management for everyone living with painful musculoskeletal conditions.

9.0 References

Arthritis Research UK 2016

Department of Health (2011). Start Active, Stay Active: a report on physical activity from the four home countries’ Chief Medical Officers
Enabling Self-management and Coping with Arthritic Pain using Exercise (ESCAPE-pain) http://www.escape-pain.org/
http://www.escape-pain.org/
A Pilot Study Exploring the Benefits of a Self-management and Exercise Programme for Newly Diagnosed People with Parkinson’s

Author: Fiona Kay, Physiotherapist, Integrated Care Team Therapy, Lightwood House

1.0 Introduction

In 2010, a piece of work remapping the care pathway for therapy services for people with Parkinson’s in Sheffield highlighted a gap in therapy services for newly diagnosed patients. The NICE guidelines for Parkinson’s (2006) suggest that people with Parkinson’s should have access to Physiotherapy, Occupational Therapy and Speech and Language Therapy from the time of diagnosis. The benefits of early access to therapy services, in maintaining independence and quality of life were highlighted in the inquiry “Please Mind the Gap: Parkinson’s Disease Services Today” (2009). This showed how a preventative approach to progressive conditions such as Parkinson’s is cost effective by avoiding hospital admission and keeping people in the community for longer and preventing crises such as falls. The inquiry also highlighted how information and signposting to services were critical to managing their condition effectively and a number of submissions to the inquiry highlighted the value of self-care courses in helping people to manage their own conditions.

The All Party Parliamentary Group for Parkinson’s report that commissioners and planners of health and social services should promote the benefits of a more preventative approach to Parkinson’s services. In light of this it was decided to run a Self-management and Exercise Programme for newly diagnosed Parkinson’s patients as a pilot study. The aim of the programme was to promote physical wellbeing as well as to increase levels of activity through exercise and promote self-management through education.

2.0 Method

This was an eight week programme of exercise and education with the aim of improving self-management of their condition and sense of wellbeing for them and their carers.

There were seven participants on the course. The referral sources were: The Parkinson’s specialist nurses, consultants in neurology or geriatrician and health and social care professionals.

The inclusion and exclusion criteria for the programme were agreed upon by a Band 7 clinical specialist physiotherapist and the Parkinson’s Specialist Nurses:

- Patients must have been newly diagnosed or diagnosed within the last two years with idiopathic Parkinson’s by a geriatrician or a neurologist.
- Patients diagnosed with parkinsonism syndromes such as Multi-System Atrophy or Progressive Supranuclear Palsy were excluded.

Although it was recognised that there was also a need for patients with Parkinsonism, it was decided that the programme would be inappropriate for these patients as they do not usually respond to Parkinson’s medication and therefore much of the self-management advice may not have been appropriate. It was also felt that the rate of progression and some of their symptoms may differ from those with idiopathic Parkinson’s.

- Hoehn and Yahr classification of 1-2.5. Patients who scored above 2.5 on the classification system were excluded. This was to ensure participants had a minimal disability and would therefore be able to exercise to a similar level.
- Patients with uncontrolled co-morbidities which would make exercising unsafe were excluded as were patients with a significant cognitive deficit that would have made it difficult for them to engage in the education module.
- Patients who had previously attended a Parkinson’s self-management programme were also excluded.

In order to ensure safe practice it was agreed that two members of staff would be present for the exercise session, one of whom would be a qualified physiotherapist. As a minimum standard all
professionals present had to be proficient in basic life support.

Prior to the programme each patient was assessed by the physiotherapist.

Patients were taught a core group of exercises to do weekly, based on the Keeping Moving Exercise Programme produced by the Parkinson’s Disease Society in 2003. These exercises were aimed at maintaining joint range of movement and preventing poor posture. Patients were also encouraged to do these exercises at home. In addition to these exercises there were also taster sessions of pilates, tai chi, dancing and circuit based exercises.

A concurrent education programme was offered at the class and the following topics were covered.

- Role of the Parkinson’s nurse specialist
- Signs and symptoms
- The benefits of exercise
- Activity Sheffield
- Management of stress and anxiety
- Current research
- Medication
- Relaxation and energy conservation
- Physical activity
- A person with Parkinson’s perspective
- The multi-disciplinary team: access to social services, speech and language therapy
- Role of Parkinson’s UK
- Recap and chance for carers to attend and ask questions

Patients were reassessed on week eight of the programme and discharged.

In order to evaluate the group patients were asked to complete weekly evaluation forms and a final evaluation form on week eight of the programme. The outcome measures used were the Hospital Anxiety and Depression Scale (HADS) (Ziigmund et al. 1983) and Measure Yourself Medical Outcome Profile (MYMOP) (Paterson 1996).

3.0 Aims and Objectives

The aims of the pilot group was to fill the gap identified in the service and provide newly diagnosed patients with appropriate advice/education and exercise in a timely manner in a community setting and to:

- Identify any logistic issues for patients attending the programme
- Identify patient benefits from attendance
- Identify potential areas for improvement

4.0 Methodology

This was a two part study: part one was a questionnaire designed to collect information from patients about the efficacy of each of the seven weekly sessions. Part two was a questionnaire that obtained feedback from patients about the programme overall. All information was co-ordinated by a clinical specialist physiotherapist.

Questionnaires were given out to all patients who attended the programme (which ran between April and June 2016).

Data was stored in SNAP Survey computer software and analysed in Microsoft Excel by the service provider’s Clinical Audit and Effectiveness Team. Outcome measures MYMOP and HADS were taken on the first and last session.

5.0 Results

Fifty-one questionnaires were completed over the eight weeks.

One participant was only able to attend three out of the eight sessions due to problems with her medication, therefore this participant was removed from the analysis.

5.1 Education

Participants were asked how useful they found the sessions attended. 90% responded that the educational sessions were useful; 69% responded they were informative and 98% responded that the information provided was easy to understand (see table 1).

100% of the attendees felt they benefitted “alot “from the education sessions. All attendees understood the information they were given.

There was one suggestion of another topic that should be included on the education programme (dietetic advice).
5.2 Exercise

All attendees were able to participate in all the exercises sessions. 67% reported that their level of activity had increased following the programme, 50% reported that the regularity of physical activity had increased and 50% reported the duration of this activity had increased.

Attendees were asked to rate the taster exercise sessions on a scale of 1-4 with one being the most enjoyable (see table 2).

<table>
<thead>
<tr>
<th>Attendee</th>
<th>Pilates</th>
<th>Tai Chi</th>
<th>Dancing</th>
<th>Games</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2: Participant rating of the exercise sessions (by type)

83% responded that the standard Keep Moving exercises were very useful and that they were doing the exercises regularly at home.

It was suggested by participants that Wii and neck stretching exercises would be useful exercises in addition to the prescribed standard Keep Moving exercises.

82% of attendees responded that if there was a similar exercise class in the community they would be interested in attending.

Patient Comments:
- “Excellent taster session”
- “I am used to exercise but Pilates was the most difficult to practise”
- “The Physio was very clear to understand”
- “No problems just new to it all”

5.3 Overall

All attendees (100%) stated the course was excellent overall. Of those who responded, all found the venue easily accessible and suitable. All participants felt the course was held at a suitable time for them; however, there was a concern raised that the venue for many participants involved a long journey.

5.4 Outcome measures

Five of the seven attendees managed to complete pre and post HADS and MYMOP questionnaires. Of these all the attendees showed an improvement on the HADS and one attendee improved on the MYMOP.

6.0 Discussion

Participant attendance throughout the course was high. Six participants had 100% attendance. The commitment to the course, despite transport difficulties and health problems serves as a proxy indicator of participant perceived benefit.
Physical exercise is known to stimulate the release of endorphins (Madsen et al 2007; Boecker et al 2008). Physiologically endorphin release is experienced as a mild opiate “high”. It has also been suggested that exercise in a group setting heightens this effect and that endorphin release might be responsible for underpinning social bonding (Cohen et al 2009). It was acknowledged that the social support that people gained from attending a group such as this is very important and the course participants appeared to be empowered by the support of other people in the group and it was them who initiated swapping contact details in order to keep in touch. All of the participants said they would be interested in attending another similar exercise class and two participants started to attend community based exercise classes which they said they would not have had the confidence to do prior to the course.

One of the aims of the course was that clients should have a greater understanding of their condition. The feedback from the participants regarding this was very positive with one person writing to thank us for the course:

“…thank you for putting together the course. I now feel as though I am managing most aspects of Parkinson’s and I learned such a lot…..”

And another said:

“I knew nothing about Parkinson’s before. Information gained during the course would have taken months to otherwise obtain - if ever! ”

The Please Mind The Gap Inquiry highlighted how information and signposting to services were critical to managing their condition effectively. All the participants said that after the course they knew where to go for help from which service.

This is reflected in the improvement in all the participants’ HADS outcome measures with one participant saying:

“it made me realise it’s [having Parkinson’s] not the end of the world”

Only one participant had a significant improvement on the MYMOP scale – this could be explained by the symptoms selected by participants for measurement within the MYMOP: tremor and/or dizziness. Such symptoms are difficult to treat and are unlikely to be altered by exercise. However, participants did report feeling better able to cope with their symptoms and it helped to know that others experienced similar symptoms.

7.0 Conclusion

The qualitative feedback from participants and the improved HADS scores suggest a self-management and exercise programme for people newly diagnosed with Parkinson’s is worthwhile and therefore such programmes could potentially fill the gap identified in service provision for this population in Sheffield. A health economic evaluation was not undertaken as part of this pilot study. As such, it was not possible to demonstrate impact on service and system level measures of interest - such as prevention of hospital admission and reduction in falls in the management of progressive conditions like Parkinson’s. Consideration of the impact of self-management interventions at patient, service and system level is necessary if physiotherapists are to evidence impact of the interventions they provide and secure funding for such interventions.

8.0 References


NICE clinical guideline 35 Parkinson’s disease Diagnosis and management in primary and Secondary care (June 2006) SIGN SIGN Diagnosis and pharmacological management of Parkinsons Disease (Jan 2010)

Parkinson’s UK Keeping Moving - Parkinson’s and Exercise Revised 2009 Accessed 30th April 2017

https://www.parkinsons.org.uk/content/keeping-moving-exercise-and-parkinsons-booklet-and-dvd


Parkinson Disease Society Quick Reference Cards (UK) and Guidance Notes for physiotherapists working with people with Parkinsons Disease (2009) 81 (2). 210-8.

Shumway-Cook A, Brauer S and Wollacott M (2000). Predicting the probability of falls in community dwelling adults using the Timed Up and Go Test in People with Parkinsons Disease. Physical Therapy

SIGN Diagnosis and pharmacological management of Parkinsons Disease (Jan 2010)


A supporting self-care intervention for older people at risk of frailty

Authors: Gill Thornton, Supporting Self-Care Coordinator, Age UK Bradford; Sarah De Biase, Healthy Ageing Programme Manager, Bradford Teaching Hospitals NHS Foundation Trust

Frailty is a condition that affects older people in which vulnerability to minor stressor events increases the risk of adverse outcomes. Older people with frailty are majority users for many health and social care services. UK health and social care systems need to better meet the needs of older people with frailty and their carers and transform the way they provide services to incorporate more preventative approaches.

A critical part of future service delivery for people living with frailty is to improve the degree to which older people become engaged in ‘self-management’ because this has the potential to provide benefits for patients and make a significant contribution to NHS efficiency.

Trust Primary Healthcare Limited, a GP Federation within Bradford and Districts Clinical Commissioning Group, in partnership with Age UK Bradford, the Academic Unit of Elderly Care and Rehabilitation at Bradford Teaching Hospitals Foundation NHS Trust and the Yorkshire and Humber AHSN Improvement Academy will establish whether a self-management support (SMS) intervention helps older people with mild frailty self-manage their health and wellbeing, and rely less on healthcare. The project will test the feasibility of a novel SMS intervention with 100 patients delivered by an Age UK Coordinator and trained Age UK volunteers and evaluate its effectiveness. They will provide information and personalised support that will help people with mild frailty to overcome their individual barriers to healthy ageing, enabling them to remain fit and independent for longer.

The intervention will incorporate the Age UK and NHS England’s ‘Practical Guide to Healthy Ageing’ (https://england.nhs.uk/wp-content/uploads/2015/09/hlthy-ageing-brochr.pdf) which contains recommendations on possible ways to help avoid the effects of ageing (such as staying active, socialising and eating well). Preliminary work has already been done with patients registered at Saltaire Medical Practice to establish the barriers and enablers to SMS for older people.

The project is supported by the Health Foundation, committed to bringing about better health and health care for people in the UK. The Health Foundation is funding the project through its Innovating for Improvement programme which supports health care projects across the UK with the aim of improving health care delivery and/ or the way people manage their own health care by testing and developing innovative ideas and approaches and putting them into practice.

For further information contact Gill Thornton at Gill.thornton@ageukbradfordanddistricts.org.uk
Two articles selected from Nederlands Tijdschrift voor Geriatriefysiotherapie (Dutch Journal of Geriatric-physiotherapy), Volume 30, October 2016, Number 3

Translation: Summaries in English by Edward Bakker MA MCSP

**Article 1**

**Interesting facts about stroke rehabilitation (pages 60-66)**

**Author:** Margriet Happel presents a succinct summary of six treatment recommendations that have emerged from the literature since the Royal Dutch Society of Physiotherapy (KNGF) published its Stroke Guidelines in 2014. She provides seven resources from which she has drawn her conclusions.

1. **Virtual reality (VR)**
   
   VR seems more effective as regards balance and gait training of post stroke patients compared with conventional therapy, whether used as a stand-alone approach or as an adjunct to conventional therapy.

2. **Fugl-Meyer arm test**
   
   This test may be used as an instrument to plan and evaluate upper-limb function, by pitching treatment intensity at the critical level of each functional score.

3. **Early stage neuromuscular stimulation**
   
   Research suggests that NMS does not add any therapeutic value to the conventional approaches to upper limb rehabilitation of patients who lack control over extension of hand and fingers. Favourable results of modified constraint-induced movement therapy in the first 26 weeks post stroke can be regarded as the result of learning new activity-strategies rather than recovery processes at the site of the neurological lesion.

4. **Rehabilitation of motor function**
   
   This process seems influenced by somato-sensory and visual disturbances and these should therefore be taken into consideration during treatment in order to optimize effectiveness.

5. **Maximum effort test**
   
   The lack of standardisation of protocols used in cardio-respiratory training programmes in post-stroke patients renders the interpretation of their results problematic.

6. **Reconsidering the notion ‘more is better’**
   
   Early mobilisation may positively affect long-term functional outcomes, but treatment frequency appears to be a more important factor than treatment duration. More treatment is not necessarily better in the acute stages of stroke.

The author recommends we access the original articles if we feel “intrigued” by the summarised conclusions presented in her article.

**Literature (Article 1)**


Heading towards the goal, together

Authors: Ank Mollema (MSc) and Sipke Douma (MSc).
Correspondence to a.mollema@vogellanden.nl

The authors explore the concept of “Zelf-Regie”. This is sometimes translated as self-management or self-directing. The translator uses the phrase ‘self-direction’ (SD) because self-management may imply a greater level of independence than some of our patients are capable of. Self-direction seems to be associated with a range of highly relevant concepts such as empowerment, control, enablement, personal autonomy, health-literacy and understanding relevant aspects of their health-environment.

The authors present the findings of their research, after presenting an introduction to the concept of self-direction and an appraisal of the literature.

The objective of their study: To explore relevant factors affecting ‘self-direction’ of the older rehabilitation patient.

The research method: Qualitative explorative design comprising a purposive sample comprising seven patients of 55+ and seven physiotherapists. The study took place between November 2015 and 2016. Data collection by semi-structured interviews ceased when saturation was achieved. A topic-guide covering four domains was used. The domains were: 1: Knowledge about own self-direction. 2: Experiences. 3: Factors influencing SD. 4: Suggestions for improvement. The patients were recruited from one institution. Data analysis was by thematic analysis.

Summary of findings:

1. Knowledge about own SD

Both samples found defining SD difficult, but seemed to understand its value.

Patients associate SD with being involved in identifying treatment goals and personal boundaries/limitations. They consider a good therapeutic relationship as essential and expect appropriate support and guidance. Some patients value a knowledgeable therapist over SD. All expect to have influence over their treatment decisions.

Physiotherapists understand SD to mean that the patient has an active role supported by the therapist who is the coach, helping the patient to make therapeutic choices. They regard it as a mutual process driven by the clinical needs as expressed by the patient. They see it as a difficult and vague term, overall.

2. Experiences

Not all of the patients had noticed they had been involved in goal setting with the therapist and they described several different ways of goal setting. It is done verbally and recorded in writing, for the patient. They value discussing and evaluating goals personally with their therapist. All participants felt that they had influence over the treatment content and that the therapist amends the treatment appropriately in accordance with their changing condition (or comments/complaints). Goal attainment seems to result in a positive experience of the physiotherapist as a coach and supporter. Patients however attribute positive treatment outcomes to some of their own personality traits as well.

Physiotherapists discuss their proposed treatment plans with their patients and some confirm it in writing, but often there is not enough time to do this.

Goals are usually in accordance with International Classification of Function: comprising short and long-term goals, supported by a staged treatment plan. The physiotherapist’s role has incrementally changed to a coaching role. Most feel adequately prepared and SD is sometimes explicitly presented as a topic during the courses they attend. All physiotherapists believe there are some issues with SD, for example when patients have cognitive impairment or limited comprehension of their situation or condition.

3. Factors influencing SD

Age does not appear to influence the extent of the patient’s SD, but older patients seemed less ambitious as regards their treatment goals and were more prepared to accept suggestions made by their therapist. Placing their trust in the therapist seemed to diminish the wish to self-direct.

From the therapists’ perspective younger patients seem less dependent on the therapist, but older patients are better at setting personal goals and adopt more of a leading role as appropriate.

4. Suggestions for improvement

Overall the participants were satisfied with the extent of their SD, but some would prefer to have more of a say in the planning of the treatment and more written information.

Physiotherapists would value more clarity around the meaning of SD.
Discussion and Conclusion

Participating patients are satisfied with their treatment even when goals weren’t set. Physiotherapists feel that they need coaching and communication skills.

Another emerging theme is bespoke care plans, which are sensitive to patients’ needs and capabilities, in order to meet individual needs. This is considered important by all participants.

Mutual trust is also regarded as an important condition together with high levels of professionalism. Clear explanations are highly valued as an aspect of the therapeutic relationship.

The therapists believe that access to relevant IT systems might support and facilitate the process of developing the patient’s SD.

Despite the acknowledged weaknesses around their study, the authors conclude that developing SD in our patients requires a consistent approach throughout the care organisation and that good quality information with supporting IT will enable patients and physiotherapists work towards common goals.

Literature and Resources (Article 2)

Braat D, Nemeton. Cursus Train de trainer. 2015.
Coulter A, Colter A. Making shared decision-making a reality. No decision about me without me. 2011.
Levack W, Mark W, Hay Smith J, Dean S, McPherson K, Siegert R. Goal setting and strategies to enhance goal pursuit for adults with acquired disability participating in reha-bilitation. 2015.
Seale C. The quality of qualitative research. Londen; 1999;
Stevens E. Eigen regie vanuit het perspectief van de client en de mantelzorger. 2014.
Vlind M. Zelfregie in de praktijk. 2012.
Weiss R. Learning from strangers. The art and method of qualitative interview studies. 1994;
www.revalidatie.nl/revalideren.
Commentary

It is not surprising that both the groups of participants were unsure as to the definition of Self Direction (SD). And yet patients and physiotherapists alike seem to understand its significance at a practical and intuitive level.

We may be much more familiar with terms such as ‘patient autonomy’, ‘control’, ‘responsibility’, ‘self-management’, ‘empowerment’, ‘enablement’ etc. But self-direction seems to be associated with all of these and seems a more rounded and comprehensive phrase. It seems to provide a ‘home’ for all the other concepts and it seems to reflect the fact that the other terms (or concepts) overlap. In other words, none of them can be said to be separate entities but all seem to be aspects of one larger concept (e.g. self-direction).

The concept of SD seems to enable us to consider the interaction within the therapeutic relationship between the two main actors (patient and therapist) as an ongoing conversation or dialogue, in which the therapist amends their role and level of leadership, on a sliding scale between coach and therapist depending on the patient’s needs, capabilities and progress/regression. Any agreements around goal setting and treatment are mutually agreed, involving an implicit or explicit ‘contract’.

As we mentioned before, the problem with the term SD is that it seems to be difficult to define, even though both groups understand and appreciate its value and benefits. Many terms and phrases within the rehabilitation and therapy lexicon have several meanings and interpretations. The term self-direction (zelf regie) refers to a range of relevant concepts and what matters is that the patients and we understand their relevance at an intuitive and moral level.

Where healthcare or rehabilitation is more protocolled, the application of the SD ethos seems more difficult to realise or it may not quite seem to fit. In those cases we ought to reflect on the question whether the ‘protocol’ is appropriate before rejecting the relevance of self-direction. Enabling SD involves valuing a particular ethos and attitude.

While the findings from qualitative studies should not be generalised to other settings, this study seems to contain valuable and insightful learning points that are at least worth reflecting on in the context of our own practice. It is important to iterate that SD does not entail making assumptions about the patient’s willingness or capability to take (some) responsibility for their treatment decisions but that it is part of a mutually respectful process of person-centred dialogical practice.
Research Update: Supporting Self-management

Author: Katie Robinson – Research Officer, AGILE

1.0 Focus on research: complex interventions

Self-management is complex and can involve a number of activities that help to support behaviour change. The complexities of self-management programmes are highlighted by Jones et al (2012) who asked therapists to reflect on a stroke self-management programme. This work emphasised the need for a change from traditional hands on therapeutic approaches towards a collaborative problem solving approach. Self-management programmes can be considered complex interventions as they involve a range of activities and interactions with a number of anticipated outcomes. Developing, understanding and evaluating complex interventions is a challenge in healthcare research. There is now a focus on gaining an understanding of the contextual factors of complex interventions, such as self-management and exploring what works, for whom and under what circumstances. This understanding may not be answered by a traditional randomised controlled trial (RCT) with strict criteria and controlled settings that do not always account for the real-life clinical setting. The Medical Research Council (MRC) (2008) have developed a guidance document for the evaluation of complex interventions to support healthcare researchers which has a focus on rigorous development prior to any formal evaluation. The MRC have developed this further and produced guidance on process evaluations for complex interventions (Moore 2015). Process evaluations can help to look at the delivery of an intervention as well as identifying the underpinning theories of how the interventions are intended to bring about change. Research that explores the contextual factors and delivery will help to ensure that interventions have relevance to a real-life clinical setting.

The MRC guidance on the stages of developing and evaluating complex interventions is presented in Figure 1. The cyclical nature emphasises the inter-dependent nature of the stages. The two-directional arrows in the development, feasibility and piloting and evaluation stage emphasise that the process is not always linear and sometimes there is a need to go back and refine certain elements before moving forward.

An example of how this guidance has been used is in the development and evaluation of the Journeying through Dementia, community based self-management programme. The concept of this intervention was developed through a review of the literature (Mountain 2006). Older people and their family carers were also consulted through research interviews (Mountain 2012) which helped to identify which components should be included in the programme as well as the best approach to delivery.

Figure 1: MRC guidance on developing and evaluating complex interventions (MRC 2008)
By rigorously developing an intervention to ensure it is acceptable to older people, their carers and those involved in the delivery it is more likely adopted and used in practice.

A feasibility study was then undertaken (Sprange 2015) which will help to inform the design of a future trial. This feasibility work helped to refine the intervention as well as look at what outcomes might be appropriate for a formal trial and whether the intended recruitment strategies were appropriate. The intervention was found to be largely acceptable to the participants and reported benefits included increased confidence and self-efficacy which identified that a future trial would need to carefully consider patient reported outcomes. This feasibility work also highlighted that recruitment strategies needed to include directly contacting potential participants 24–48 hours after being invited to the study. This feasibility work has led to a RCT which is currently underway to evaluate the Journeying through Dementia programme using a larger number of people (http://www.bradford.ac.uk/health/dementia/research/journeying-through-dementia/).

This is just one example of the development and evaluation of a complex therapy intervention and emphasises the importance of including patients and carers throughout the process.

Other examples of the development and evaluation of self-management programmes are highlighted by the following examples:

**OA Go Away: Development and Preliminary Validation of a Self-Management Tool to Promote Adherence to Exercise and Physical Activity for People with Osteoarthritis of the Hip or Knee**

**Authors:** Paterson et al 2016

**Purpose:** To determine the face and content validity, construct validity, and test–retest reliability of the OA Go Away (OGA), a personalized self-management tool to promote adherence to exercise and physical activity for people with osteoarthritis (OA) of the hip or knee.

**Methods:** The face and content validity of OGA version 1.0 were determined via interviews with 10 people with OA of the hip or knee and 10 clinicians. A revised OGA version 2.0 was then tested for construct validity and test–retest reliability with a new sample of 50 people with OA of the hip or knee by comparing key items in the OGA journal with validated outcome measures assessing similar health outcomes and comparing scores on key items of the journal 4–7 days apart. Face and content validity were then confirmed with a new sample of five people with OA of the hip or knee and five clinicians.

**Results:** Eighteen of 30 items from the OGA version 1.0 and 41 of 43 items from the OGA version 2.0 journal, goals and action plan, and exercise log had adequate content validity. Construct validity and test–retest reliability were acceptable for the main items of the OGA version 2.0 journal. The OGA underwent modifications based on results and participant feedback.

**Conclusion:** The OGA is a novel self-management intervention and assessment tool for people with OA of the hip or knee that shows adequate preliminary measurement properties.

**Exercise and fall prevention self-management to reduce mobility-related disability and falls after fall-related lower limb fracture in older people: protocol for the RESTORE (Recovery Exercises and STepping On afteR fracturE) randomised controlled trial.**

**Author:** Sherrington 2016

**Background:** Lasting disability and further falls are common and costly problems in older people following fall-related lower limb and pelvic fractures. Exercise interventions can improve mobility after fracture and reduce falls in older people; however the optimal approach to rehabilitation after fall-related lower limb and pelvic fracture is unclear. This RCT aims to evaluate the effects of an exercise and fall prevention self-management intervention on mobility-related disability and falls in older people following fall-related lower limb or pelvic fracture. Cost-effectiveness of the intervention will also be investigated.

**Methods/Design:** A RCT with concealed allocation, assessor blinding for physical performance tests and intention-to-treat analysis will be conducted. Three hundred and fifty people aged 60 years and over with a fall-related lower limb or pelvic fracture, who are living at home or in a low care residential aged care facility and have completed active rehabilitation, will be recruited. Participants will be randomised to
receive a 12-month intervention or usual care. The intervention group will receive ten home visits from a physiotherapist to prescribe an individualised exercise program with motivational interviewing, plus fall prevention education through individualised advice from the physiotherapist or attendance at the group based “Stepping On” program (seven two-hour group sessions). Participants will be followed for a 12-month period. Primary outcome measures will be mobility-related disability and falls. Secondary outcomes will include measures of balance and mobility, falls risk, physical activity, walking aid use, frailty, pain, nutrition, falls efficacy, mood, positive and negative affect, quality of life, assistance required, hospital readmission, and health-system and community-service contact.

Discussion: This study will determine the effect and cost-effectiveness of this exercise self-management intervention on mobility-related disability and falls in older people who have recently sustained a fall-related lower limb or pelvic fracture. The results will have implications for the design and implementation of interventions for older people with fall related lower limb fractures. The findings of this study will be disseminated in peer-reviewed journals and through professional and scientific conferences.

Acknowledgements
For further information please contact: Katie Robinson (AGILE Research Officer) - researchagile@gmail.com

References


AGILE Research
Are you interested in getting involved in research or improving the service you work in?

Our AGILE Research Officer is keen to hear from members who are doing any research or service improvement work as well as members who would like information about how to get more involved.

Look out for opportunities to share your work at the AGILE conference this year - it would be great to hear about all the work going on and you never know you might get a taste for presenting!

Please contact Katie Robinson on researchagile@gmail.com
Article title: Promoting self management and adherence with strength and balance training for older people with long-term conditions: a mixed methods study.

Article authors: Robinson, L, Newton, JL, Jones, D, Dawson, P 2014

This journal was reviewed using the Mixed Methods Appraisal Toolkit (Pluye et al 2011).

2.0 Introduction

2.1 Was there a clear statement of the aim of the research?

This paper aimed to explore the process of behaviour change in a small sample of older people with fall-associated primary biliary cirrhosis (PBC) in relation to different durations and types of strength and balance training (SBT) interventions. It also aimed to explore the effect of the different SBT interventions on self-management and long-term adherence.

This was thought to be important as although SBT is one of the most effective ways for community-dwelling older people to reduce their risk of falling, there is poor uptake of simple exercise interventions in the community and further attrition through drop-out and non-adherence.

This is particularly relevant to teams treating older people, given the costs associated with falling (Chartered Society of Physiotherapy 2014), and the issues associated with compliance with SBT. However, it should be noted that the patient group involved in the study was people with primary biliary cirrhosis; therefore results should only be extrapolated to a general older population with caution.

This paper is part of a larger study, and therefore it was quite difficult at times to ascertain the exact purpose of this paper, when read in isolation.

3.0 Methodology

A mixed methods design was used. Semi-structured interviews were conducted, with graphical representations of patient reported outcome measures to facilitate the discussion. Patients underwent either a standard or enhanced individualised programme of SBT, with the difference outlined in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>Enhanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline quantitative data collection phase</td>
<td>3 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Frequency of clinical sessions</td>
<td>Once per week</td>
<td>Once every four weeks</td>
</tr>
<tr>
<td>Duration of clinical sessions</td>
<td>30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Number of sessions</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Total number of weeks for the intervention</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Quantitative follow up data collection phase</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Clinician seen</td>
<td>Nurse</td>
<td>Physiotherapist</td>
</tr>
</tbody>
</table>

The enhanced group were also encouraged to become autonomous in their management of exercise behaviour, but there is no detail provided about how this was done.

3.1 Is the source of qualitative data relevant to address the research question?

Semi-structured interviews were a relevant choice of method to explore participants’ experiences of the two strength and balance training interventions.

3.2 Was the analysis used appropriate?

Framework analysis was used to analyse the qualitative data. This was in line with the exploratory nature of the study and enabled themes to emerge from the data.
3.3 Was the sampling strategy relevant to address the quantitative aspect of the mixed methods question?
Consecutive patients who were attending an outpatient liver clinic and who met the inclusion criteria were invited to participate in the study. Recruiting consecutive patients is in line with case series recruitment.
Nine participants were recruited in total, but there is no detail on why this number was chosen.

3.4 Are they representative?
The sample group were not representative, and it is unclear whether they were intended to be or not. Given the qualitatively driven methodology, it may be that representation of the wider population was not required. However, the title of the paper is quite misleading as it refers to “patients with long-term conditions” rather than specifically mentioning PBC.
Whilst the inclusion criteria are stated, there are no explicit exclusion criteria, therefore these can only be implied. One of the inclusion criteria was that the individual needed to be medically stable, although there is no further detail as to how this was ascertained.
In light of the criteria and specificity of the group, the results may not be transferable to patients who are medically unstable, or those with cognitive impairment.

3.5 Was the appropriate data collected?
The quantitative data collected includes the falls efficacy scale, a health related quality of life scale specifically for people with PBC, and the self-efficacy for exercise scale. These are all patient reported outcomes which aligns with the purpose of the quantitative data.
There was an acceptable response rate, with only one participant lost to follow up, and therefore this individual did not participate in the semi-structured interviews.

3.6 Is the mixed methods research design appropriate to answer the question?
An appropriate design has been developed as the purpose of the paper is exploratory in nature.

3.7 Is the integration of the data relevant to the research question?
The integration of the two types of data was appropriate, with the quantitative data used to facilitate the discussion in the semi structured interviews. The quantitative data was also used to ratify the themes that emerged, thereby triangulation the results.

4.0 Findings
The demographics of the recruited participants is represented in tabular form. All participants were female and therefore not representative of the wider population.
The findings were split into two themes, as outlined below. There was less focus on quantitative data, with graphical depictions of the patient reported outcome measures being used to illustrate some of the quotations provided to support the theme. This is in line with the qualitatively driven methodology.

4.1 From polite compliance to personal relevance
Reasons for participating
Participants’ main motivation to participate was to take part in research, and because they had committed to the research study they felt they should complete their exercises. There was no indication that people were motivated by wanting to decrease their risk of falling.
Experience of participating
The participants receiving the standard intervention did not feel that the exercises were specifically tailored to them, and therefore were not as useful. However, the participants who were in the enhanced group felt they had more ownership over their exercises as there was a longer period between face to face contact, and they could progress their exercises themselves.
Longer term participation
The longer length of the enhanced intervention led to better compliance. The enhanced intervention lasted a longer period of time which appeared to be associated with long-term active participation throughout the case series.

4.2 From self-efficacy to self-realisation
Self-efficacy for exercise
There were large fluctuations in self-efficacy throughout the case series, but those who had high self-efficacy on commencing the programme found it easier to continue to adhere to the exercise programme.
Managing fatigue
This highlights the need to consider the other symptoms alongside the long-term condition. However, high levels of fatigue were not actually a barrier to participating with the exercises.

Reducing fear of falling
The intervention seemed to decrease participants’ fear of falling, and one example of an individual’s falls efficacy scale was shown. However, it was also noted that the fatigue experienced still had an impact on their fear of falling.

Self-realisation
Participants developed an appreciation of the benefits of home exercise programme.

5.0 Discussion
Patients had self-selected to participate in the study, and this was acknowledged during the findings, as indicated by the theme “deciding to participate”. However, the potential impact this may have on the participants’ willingness to commit to the exercise programme in the longer term was not acknowledged by the authors.

The interventions were delivered by different people from different backgrounds, which makes them two distinct interventions rather than standard and enhanced, and it may have been clearer to distinguish them as such. The authors recognise that they have not explored how the personal relationship with either the nurse or physiotherapist may impact on the participants’ adherence to the exercises.

There was recognition during the study that the results are not necessarily very applicable to current practice.

Finally, the completion of exercises was self-reported and may have been influenced by the participants continuing to feel that they are being monitored during the 6 month follow up data collection phase. This does indicate that self-management support can promote ongoing participation, as opposed to no further follow up after the intervention as finished.

to understand where any issues are with self-management and exercise adherence.

- If patients are able to continue with exercises independently, including progressing the exercises, they may be more likely to have increased ownership over the exercises.

- It may be necessary to alter the pattern of service. For example, having the same amount of face to face contact over a longer period of time may lead to increased self-efficacy. This does highlight that people who are being enabled to self-manage their condition will still need to have healthcare input during the progression of their condition.

- The lack of standardised appraisal tool such as the Critical Appraisal Skills Programme (2017) has made analysing a mixed methods paper more challenging.

Acknowledgements
For further information please contact: Professor Pamela Dawson (pamela.dawson@northumbria.ac.uk)

References
Chartered Society of Physiotherapy (2014) The cost of falls [online]


Can Personalised Activity Plans Reduce the Amount of Time Hospitalised Older People Spend Being Inactive?

Author: Gavin Snelson, Clinical Team Lead Physiotherapist Older Peoples Medicine, Newcastle upon Tyne NHS Foundation Trust

Introduction

In recent years there has been increasing attention on inactivity and sedentary behaviour in older people. Barnes et al (2012) defined sedentary time as when sitting or lying is the dominant posture and energy expenditure is very low. The 2011 Start Active, Stay Active guideline from the Chief Medical Officer recommended that older people should minimise the amount of time spent being sedentary for extended periods (Department of Health (DOH) 2011). The Chartered Society of Physiotherapy (CSP) further added that older adults should be encouraged to stand up more frequently (CSP 2011). There is also a drive from NHS England to reduce the risk of avoidable harm and help people to recover from episodes of ill health in the NHS Outcomes Framework 2014-2015 (DOH 2014). Inactivity could be viewed as an avoidable harm due to the associated increased risks of cardiovascular, respiratory, haematological, gastrointestinal, endocrine, renal, immune and skin complications (Knight et al 2009). A recent systematic review by Biswas et al (2015) also found increased risks associated with sedentary time over the longer term including all-cause mortality, cardiovascular disease, cancer incidence and type-two diabetes.

In a recent study it was observed that older people on acute medical wards spent the majority of their time either sitting or lying down on the bed, suggesting that this population is at high risk of complications associated with inactivity (Kyus et al 2012). As time spent inactive increases with age it would suggest that this population is especially vulnerable to the adverse effects of sedentary time (The NHS Information Centre 2009). Studies conducted by Burton et al (1995), Gardiner et al (2011) and Fitzsimons et al (2013) all looked at interventions to reduce inactivity in older people. Unfortunately all the interventions were poorly described making them difficult to recreate. All of the studies reported a reduction of the time spent inactive measured using questionnaires and accelerometers. There were some limitations in terms of selection bias in each of these studies. All of the studies involved a one to one meeting with a health care professional focusing on discussion of inactivity. This one to one discussion with a health care professional focused on inactivity was thought to be an important factor in influencing activity levels. Empowerment over your own health is a priority for the NHS according to Darzi (DOH 2008; Keogh 2013).

There is already a weight of evidence to suggest the acute risks of inactivity in older people and previous studies have shown older inpatients to spend a large proportion of their time in hospital being inactive. Studies by Burton et al (1995), Fitzsimons et al (2013), and Gardiner et al (2011) have suggested that a healthcare professional can influence the amount of time older people spend inactive; however, the studies were not targeted at older adult inpatients. The interventions used were not described sufficiently to suggest a particular approach.

The aim of this project was to introduce an intervention called a personalised activity plan (PAP) using the Plan, Do, Study, Act (PDSA) model of change facilitation in order to further develop an intervention aimed at reducing inactivity levels among older in-patients and to assess the feasibility of such an intervention.

2. Methodology

2.1 Design

A cyclical model of change management was used in the design called the PDSA model. This allowed for multiple test cycles to develop the PAP. Assessing one patient at a time for impact and making changes leading to improvement (NHS Institute for Innovation and Improvement 2012). This meant the intervention could be easily updated and changed between cycles to improve the intervention in response to feedback from participants. A quantitative evaluation approach was used as the main aim of the practice project was to measure reductions in inactivity levels. The main outcome was the time spent inactive. A non-probability convenience sample of older inpatients on specialist older people’s wards was used. This had
an advantage of simplicity but the disadvantage in a lack of potential to generalise to a wider population (Bryman 2008).

2.2 Participants

Five participants were recruited: two male and three female, age range 73-94 (mean 80.4 years) using a convenience sample of inpatients on specialist older people’s wards. The reasons for admission included falls, seizure and delirium. All the patients had at least one long-term condition including chronic obstructive pulmonary disease (COPD), osteoarthritis (OA) and cerebrovascular accident (CVA). No patients had discussed sedentary time or inactivity prior to participation and enrolment was voluntary. It was made clear that participation would not affect usual care (specifically access to physiotherapy or rehabilitation) on the ward nor patient discharge. Inclusion criterion were admission to a specialist older people’s ward, aged over 65 years, medically stable as defined by a doctor at handover, having mental capacity and being able to stand up either independently or with minimal assistance of one other person.

2.3 Apparatus

ActivPAL™ accelerometers were used to measure the amount of inactive time spent by participants. The ActivPAL™ has been shown to be both valid (Aminian and Hinckson 2012) and reliable (Dahlgren et al 2010) in relation to the assessment of posture. Time spent sedentary for this project was considered to be non-upright activities such as sitting or lying (Matthews et al 2008).

2.4 Procedure

Participants wore the accelerometer attached to their right wrist for 12 hours to monitor a baseline level of inactivity from 8am until 8pm. Levels of inactivity were then discussed with the patient and a PAP formulated to reduce the levels of inactivity by providing targets every hour over the next 12 hour monitoring period. The next day participants followed the PAP whilst wearing the accelerometer again from 8am until 8pm. The effect of the PAP was then discussed with the participant to get feedback on their experience and check the acceptability. The accelerometer recorded the time spent sedentary as either time lying down or sitting and time spent active as time upright or mobilising. It additionally recorded the number of sit to stand events and the amount of time between the standing events.

2.5 Ethics

Ethical approval was given by the Trust Research and Development Department who considered the proposal to be within the scope of a practice project. Participants were given information sheets and signed consent forms. Participants were also given assurance about confidentiality and their right to withdraw at any time from the project. Participants were only approached by physiotherapists not involved in their direct treatment to minimise coercion.

3.0 Results

(See Table 1)

Participants spent an average 700 minutes either sitting or lying down out of 720 minutes monitored. This equates to 20 minutes of activities spent in standing and 97 per cent of their spent inactive. Sedentary time reduced after the introduction of the PAP by an average of 23 minutes, from 700 to 677 minutes. Sedentary time reduced from 97% of a participant’s day to 94% giving a 3% reduction. The

Table 1: Data shown from before the PAP and after PAP intervention including, Sedentary Time minutes, the number of Sit to Stand Events, and Number of Steps taken

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>696.8</td>
<td>675.3</td>
<td>19</td>
<td>26</td>
<td>42</td>
<td>332</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>679.4</td>
<td>664.5</td>
<td>21</td>
<td>22</td>
<td>150</td>
<td>150</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>709.3</td>
<td>683.9</td>
<td>3</td>
<td>25</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>708.4</td>
<td>674.1</td>
<td>12</td>
<td>44</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>707.7</td>
<td>687.5</td>
<td>6</td>
<td>26</td>
<td>8</td>
<td>54</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>700.32</td>
<td>677.06</td>
<td>12</td>
<td>29</td>
<td>42</td>
<td>108</td>
<td>3.2</td>
<td>1</td>
</tr>
</tbody>
</table>

Key: ST= Sedentary time; PAP= Personalised Activity Plan; No. Stands= Number of sit to stand events; LTWS (hrs)= Longest time without standing during 12 hours monitoring
number of steps taken showed variable results. Two participants showed improvement, two remained the same and one reduced the amount of steps taken. Overall the average reflected an increase in the number of steps recorded. The average number of sit to stand events increased from 12 to 29 and the longest recorded time without standing reduced from 3.2 hours to one hour on average.

Chart 1: Sedentary Time before and after implementation of PAP

Chart one shows the general trend towards less sedentary time after the PAP was introduced.

4.0 Discussion

The PAP was thought to be acceptable to all the patients who participated. Once the PAP was introduced there was a 3% reduction in the amount of time spent being inactive. The number of standing events increased and the longest time recorded between stands decreased. The results support the earlier finding of Kuys et al (2012) that demonstrated older inpatients spent the majority of their time either sitting or lying down. It also supports the work of Burton et al (1995), Gardiner et al (2011) and Fitzsimons et al (2013) who showed that sedentary time could be reduced in older people through the interaction between a health care professional and older person. Empowerment over your own health is a priority for the NHS according to Darzi (DOH 2008; Keogh 2013). It could be suggested by working collaboratively with older inpatients to develop PAPs patients were empowered to have greater control over their own recovery. One unexpected finding was the amount of time participants were recorded as being inactive before they started the PAP. One participant was recorded as not moving for six hours yet all participants had some ability to move independently.

There are a few limitations to the project. The methodology used was quantitative and the absence of a control group affects the ability to imply causation from the results. A convenience sampling method used which limits the reliability of the findings and the ability to generalise the results to a wider population (Bryman 2008). One issue which could have influenced the results is the Hawthorne effect. Once participants were being monitored they might have changed their behaviour to be more active and this could influence the validity. Monitoring participants over a longer period of time could reduce the influence of the Hawthorne effect. There are also limitations with the ActivPAL™ accelerometer as the step count did not reflect the number of steps taken. One of the participants had recorded mobilising on their PAP but no steps were measured by the device. This could be because the patient had an antalgic walking pattern that affected the step count on the accelerometer.

5.0 Conclusion

It seems to be acceptable to talk to patients about sedentary time in hospital and patients found they were able to participate in PAPs. Future research could focus on the potential for personalised activity plans to reduce the time spent inactive on a larger more representative cohort of hospitalised older people. Engagement with this patient group could improve the understanding as to why older inpatients spend such a large proportion of time inactive, even when they are able to mobilise independently. A larger study might also be able to develop the reliability and validity of the PAP intervention.

References


Dahlgren, G., Carlson, D., Moorhead, A., Hager-Ross, C. and


Person Centred Pathway of Care for Mental Health Services for Older People Physiotherapy: Functional Clinical Link Pathway (CLiP)

Author: Chris Potts, Specialist Physiotherapist and Peter Baines, Specialist Physiotherapist; Sedgefield and Dales Community Team/In-patients, Auckland Park Hospital

1.0 Local Context

Our intention is to provide the highest quality integrated mental health care based upon the principles of evidence based practice and within the context of “No Health Without Mental Health” (DOH 2011), Making mental health services more effective and accessible (DOH 2013) and NICE guidance, including clinical guideline 91 ‘Depression in adults with a chronic physical health problem’ (NICE 2009).

In developing our service, Mental Health Services for Older People (MHSOP) considered three main and three associated pathways: Dementia, Affective Disorders and Psychosis; and three associated pathway: falls, behaviours that challenge and malnutrition. It is anticipated that these care pathways are likely to cover approximately 90% of people who use our services. The MHSOP Functional CLiP was developed following the development of the MHSOP Affective Disorders Pathway.

Functional CLiP is designed to guide Physiotherapists in MHSOP in managing patients with a functional illness and should be used as an adjunct to the main Affective Disorders Pathway. The CLiP is evidenced based and supported by the following NICE guidelines: Public Health guideline 44 ‘Physical activity: brief advice for adults in primary care’ (2013); NICE guideline 49 ‘Behaviour Change. Individual Approaches’ (2014), NICE guideline 82 ‘Schizophrenia: core interventions in the treatment and management of schizophrenia in adults in primary and secondary care’ (2009); NICE guideline 90 ‘Depression in Adults. The Treatment and Management of Depression in Adults’ (2009); NICE guideline 91 ‘Depression in adults with a chronic physical health problem’ (2009); NICE guideline 113 ‘Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. Management in primary, secondary and community care’ (2011); and finally, NICE guideline 161 ‘Falls: Assessment and prevention of falls in older people’ (2013). These supporting documents demonstrate strong evidence of the link between physical health and mental wellbeing.

Health promotion is a proactive way of improving both the physical and mental health of patients and physiotherapists are well placed to lead on the provision of such interventions. The Functional CLiP is a guide for physiotherapists from referral, assessment of patients and delivery of health promotion interventions. The main focus of Functional CLiP is that of exercise to improve physical fitness, impacting both on physical and mental wellbeing. Functional CLiP outlines the appropriate patient reported outcome measures (PROMS) and clinician reported outcome measures (CROMS) to be used to inform treatment effectiveness, underpinned by evidence base.

2.0 The Programme

Patients are referred via the MHSOP multidisciplinary team (MDT) for screening/inclusion on the 12 week programme following a personalised training programme combined with a Functional Fitness MOT programme. Outcome measures include the POMA (Performance-orientated mobility assessment) Gait and Balance, the Functional Fitness MOT and MYMOP2 – measures are completed at entry and exit of programme.

Health promotion is provided with topics supported by the written information – using Age UK documents ‘A Practical Guide to Healthy Ageing’ and ‘Healthy Living – Maintaining a healthy body and mind’.

The table below shows the 12 week Functional CLiP programme content and outcomes measured.
# Health Promotion, Wellbeing And Exercise - 12 Week Physiotherapy Lead Programme

<table>
<thead>
<tr>
<th>EXERCISE</th>
<th>HEALTH PROMOTION</th>
</tr>
</thead>
</table>
| **WEEK 1-4**  
Once weekly physiotherapy team led exercise session.  
Structure of 1-4 sessions will include:  
• warm up component (pulse & respiratory rate raiser, joint mobilisation, gentle muscle activation, short stretches, re-warm) for approx. 10-15 minutes,  
• core (aerobic/strengthening/flexibility/balance) exercise component 25-40 minutes.  
• cool down/relaxation of 10-15 minutes approximately to gentle return body to normal state incorporating pulse lowering and maintenance/developmental stretches as appropriate to promote and increase flexibility.  
Using modified BORG 0-10 perceived rate of exertion scale individuals will aim to be working at 4-5/10 intensity (lower intensity as people acclimatised to exercise). To facilitate this, lower rep and set scheme will be used, with longer more frequent rest periods, less resistance. Example of reps would be 4-8 with 1-3 sets. | **WEEK 1**  
Introduction  
**WEEK 2**  
Stay Active  
**WEEK 3**  
Healthy Eating  
**WEEK 4**  
Maintaining a Healthy Weight |
| **WEEK 5-9**  
#Note – repeat MYMOP2 & 8 foot up and go (balance strength and mobility) & 6 minute walk (aerobic endurance) at WEEK 6  
Structure of sessions 5-9 will include:  
• warm up component (pulse & respiratory rate raiser, joint mobilisation, gentle muscle activation, short stretches, re-warm) for approx. 10-15 minutes,  
• core (aerobic/strengthening/flexibility/balance) exercise component 25-40 minutes.  
• cool down/relaxation of 10-15 minutes approximately to gentle return body to normal state incorporating pulse lowering and maintenance/developmental stretches as appropriate to promote and increase flexibility.  
Using modified BORG 0-10 perceived rate of exertion scale individuals will aim to be working at 5-7/10 intensity (low-moderate intensity as abilities increase). Higher reps, increased distance, reduced rest periods. Example of number of reps would be 6-10 with 3-5 sets. | **WEEK 5**  
Alcohol Consumption  
**WEEK 6**  
Sleep Hygiene (physio related)  
**WEEK 7**  
Physical Health Checks  
**WEEK 8**  
Footcare and footwear  
**WEEK 9**  
Smoking Cessation |
| **WEEK 10-12**  
#Note – Complete final MYMOP2 & MOT  
Structure of sessions 10-12 will include:  
• warm up component (pulse & respiratory rate raiser, joint mobilisation, gentle muscle activation, short stretches, re-warm) for approx. 10-15 minutes,  
• core (aerobic/strengthening/flexibility/balance) exercise component 25-40 minutes.  
• cool down/relaxation of 10-15 minutes approximately to gentle return body to normal state incorporating pulse lowering and maintenance/developmental stretches as appropriate to promote and increase flexibility.  
Using modified BORG 0-10 perceived rate of exertion scale individuals will aim to be working at maintaining an intensity of 7/10 (moderate-higher intensity as abilities maximise). Higher reps, increased distance, minimal rest periods. Example of number of reps would be 12-20 with sets 5-6.  
To complete surveys: Where next? and Patient Survey | **WEEK 10**  
Falls  
**WEEK 11**  
Local Groups  
**WEEK 12**  
Summary |
3.0 Outcomes

3.1 PROM
Measure Yourself Medical Outcome Profile 2 (MYMOP2): aims to measure the outcomes that the patient considers the most important. The patient chooses one or two symptoms that they are seeking help with, and that they consider to be the most important. They also choose an activity of daily living that is limited or prevented by this problem. These choices are written down in the patient’s own words and the patient scores them for severity over the past week on a seven-point scale. Lastly wellbeing is scored on a similar scale. Several published studies have shown that MYMOP is practical, reliable and sensitive to change.

Table 2: Improvement in MYMOP following 12 week Functional CLiP

<table>
<thead>
<tr>
<th>Patient</th>
<th>% improvement post 12 week Physio Functional CLiP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24%</td>
</tr>
<tr>
<td>2</td>
<td>23%</td>
</tr>
<tr>
<td>3</td>
<td>44%</td>
</tr>
<tr>
<td>4</td>
<td>44%</td>
</tr>
<tr>
<td>5</td>
<td>24%</td>
</tr>
<tr>
<td>6</td>
<td>Unable to repeat scoring</td>
</tr>
</tbody>
</table>

Table 2 shows the percentage improvement after a 12 week Functional CLiP programme for the first cohort of patients recruited to the programme.

3.2 Functional Fitness MOT
This has been developed in conjunction with Glasgow Caledonian University, Later Life Training and the British Heart Foundation National Centre for Activity and Health (2012). Within the MOT are seven evidence based clinical reported outcome measures (CROMs) which can be assessed. The choice of CROM is decided by the physiotherapist following a person centred assessment. Not all of the CROM’s need to be used. Once CROM(s) are chosen, the patient is assessed and the outcome is charted on a graph within the MOT. This enables the patient to see their level of functioning prior to commencing the 12 week programme. They also fill out the activity questionnaire and develop their own action plan to try and improve fitness. At the end of the 12 week programme the CROMs are retested and re-charted and their action plan reviewed. This allows the individual to see their improvement over the 12 weeks programme.

The seven CROMs which can be used are:
1. 30 second chair stand
2. Chair sit and reach
3. Back scratch
4. Eight foot up and go
5. Handgrip strength
6. Single leg stand
7. Six minute walk test

Table 3 highlights the improvements in the Functional Fitness MOT for six participants, demonstrated by the percentage improvement in each of the CROMs.

Table 3: Improvement in CROMs following 12 week Functional CiP

<table>
<thead>
<tr>
<th>Patient</th>
<th>% improvement (increase) in CROMS post 12 week Physio Functional CLiP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CROM 1 12.5% CROM 2 - CROM 3 - CROM 4 - CROM 5 - Right leg: 300% Left leg: 100% 97%</td>
</tr>
<tr>
<td>2</td>
<td>CROM 1 11% CROM 2 - CROM 3 - CROM 4 - CROM 5 - Right leg: 200% Left leg: 500% 16%</td>
</tr>
<tr>
<td>3</td>
<td>CROM 1 12.5% CROM 2 - CROM 3 - CROM 4 - CROM 5 - Right leg: 200% Left leg: 500% 46%</td>
</tr>
<tr>
<td>4</td>
<td>CROM 1 9.09% CROM 2 - CROM 3 - CROM 4 - CROM 5 - Right leg: 200% Left leg: 150% Unable to assess</td>
</tr>
<tr>
<td>5</td>
<td>CROM 1 16.67% CROM 2 - CROM 3 - CROM 4 - CROM 5 - Right leg: 0% Left leg: 66.67% 170%</td>
</tr>
<tr>
<td>6</td>
<td>Unable to repeat Unable to repeat Unable to repeat Unable to repeat Unable to repeat Unable to repeat Unable to repeat</td>
</tr>
</tbody>
</table>
4.0 A Functional CLiP Case Study

Participant background – 70 year old female, Mrs J, with recurrent depressive disorder and physical deconditioning and perceived reduced strength/reduced exercise tolerance/reduced social engagement. Service user had not historically been active (for example, been a gym goer) but had enjoyed walking. A participant defined goal was to regain ability to walk for greater distance and durations.

Programme participation – Mrs J completed the full 12 week programme, completing approximately two hours of exercise and health promotion including warm up/cool downs/discussion and education.

Mrs J expressed how much she enjoyed the programme, how she had noticed her health and wellbeing/physical and mental health improve, and her enjoyment of the social benefits of the attending the group.

Post programme feedback – The participant expressed a wish for the group to continue but fully accepted that programme was of a set duration and therefore, the subsequent need to have autonomy to continue exercise in the community once the sessions concluded.

Post programme personal exercise plan – Mrs J intends to join a gym and has a subsequent induction arranged. Mrs J attends with her partner and also intends to begin to swim as a form of exercise. She and a fellow participant from the group exchanged contact details and plan on keeping in touch.

Results

The following outcome measures were used. These measures form constituent parts of the Personal Fitness MOT document developed by Glasgow Caledonian University, Later Life Training and the British Heart Foundation National Centre for Physical Activity and Health (2012).

<table>
<thead>
<tr>
<th>TEST / OUTCOME MEASURE</th>
<th>PRE GROUP SCORE</th>
<th>POST GROUP RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 second chair stand (Using arms)</td>
<td>12 stands</td>
<td>12 stands</td>
</tr>
<tr>
<td>8 foot up and go (aid)</td>
<td>10 seconds</td>
<td>4.5 seconds</td>
</tr>
<tr>
<td>6 minute walk (aid)</td>
<td>340 metres</td>
<td>420 metres</td>
</tr>
</tbody>
</table>

MYMOP (Measure Yourself Medical Outcome Profile 2002 Bristol University) scores:

<table>
<thead>
<tr>
<th>MYMOP 2</th>
<th>Symptom 1 score</th>
<th>Symptom 2 score</th>
<th>Activity score</th>
<th>Wellbeing score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced strength - 4</td>
<td></td>
<td></td>
<td>Walking -3</td>
<td>3</td>
</tr>
<tr>
<td>Reduced fitness / exercise tolerance -3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MYMOP2 FOLLOW UP</th>
<th>Symptom 1 score</th>
<th>Symptom 2 score</th>
<th>Activity score</th>
<th>Wellbeing score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced strength - 3</td>
<td></td>
<td></td>
<td>Walking - 2</td>
<td>1</td>
</tr>
<tr>
<td>Reduced fitness / exercise tolerance -2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.0 Analyses post program

Improvements in all outcome measures both physical and mental health and wellbeing evidenced with service user progressing well and achieved personal goals as established at commencement of group. All other participants of the group made similar measured improvements in physical and mental health. A further three groups are planned in 2017.

6.0 Bibliography

Borg Rating of Perceived Exertion (RPE) Scale (1998)

Functional Fitness MOT . Glasgow Caledonian University, Later Life Training and the British Heart Foundation National Centre for Physical Activity and Health (2012)

Measure Yourself Medical Outcome Profile (MYMOP2) (2002). http://www.bris.ac.uk/primaryhealthcare/resources/mymop/questionnaires/


7.0 References

Department of Health (July, 2011). Start active, stay active: a report on physical activity from the four home countries’ Chief Medical Officers.
NICE guideline; 90; Depression in Adults. The Treatment and Management of Depression in Adults. National Institute for Health and Care Excellence. (October 2009)
NICE guideline; 91; Depression in adults with a chronic physical health problem. National Institute for Health and Care Excellence. (October, 2009)
NICE guideline; 113 ; Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. Management in primary, secondary and community care. National Institute for Health and Care Excellence. (January 2011).
NICE guideline; 161; Falls: Assessment and prevention of falls in older people. National Institute for Health and Care Excellence. (June 2013)
An Exploratory Observation Study: Can Music Facilitate Therapeutic Engagement in Self-management in Older Adults

Author: Kolapo Jegede, Physiotherapist, St. Mary’s Hospital, Northamptonshire Foundation Trust NHFT

1.0 Introduction

Music (vocal & instrumental) is a sensory activity many people respond to in different way depending on the rhymes. The motor response transduced from the sensory inputs of music is of interest in the therapeutic engagement with acute mental health inpatients for older adults in this observational study.

The motor response has been of significant importance for assessing 180 degree turning, timed unsupported standing and overall spatial balance of older adults that lack mental capacity to engage in formal assessment. Music has been explored and trialled to facilitate physiotherapy delivery while in hospital and is currently being risk assessed for patients’ “self-management” in the community.

This article reports on the observation of the effect of music on the patients admitted to an older person’s in-patient mental health unit.

2.0 Background

According to NICE guidelines (PH54 2014) factors such as cognitive decline, depression and age-related physiological changes are common among an ageing population. Therefore, there is need for more professionals to design/adapt physical activity programmes for older people that reflect their preferences and are delivered in a community setting. NICE (2014) states these physical activity programmes should include mixed exercises of moderate intensity such as dancing, walking & swimming.

Physiotherapists are among the professionals challenged in the context of this article especially when attempting to engage older patients with mental health conditions in dancing with music. This is not least because physiotherapists must undertake an appropriate risk assessment before recommending music and dancing as a self-management strategy for a population whose judgement and internal risk assessment ability may be sub-optimal.

3.0 Literature Review

3:1 Self-management with music

Healthy ageing should explore older people’s abilities to self-regulate or self-manage their lives and ageing processes. Self-management ability of older adults should involve regular exercises and healthy eating (Jane et al 2014). Self-management involves the person having an insight into the cause of the illness; manage their care by taking medication and participating in decision making with their health providers regarding the illness (Jane et al 2014).

Self-management of older adults could involve the use of music led exercises. Music serves to calm and uplifts the mood of patients, and these effects can last for days or even weeks after the therapy session has taken place. Some patients even experience increased cognitive functioning for this period (Sacks 2007). Music can be used to maintain memory organisation and thought processing. Listening, singing, dancing and other movement elicited due to the effect of music can aid in improving range of movement, endurance, strength, balance, functional hand movements, finger dexterity and limb coordination (MTCCA 2005).

Dance is a part of life and it is for everyone – it is about expressing feelings of joy, grief. It is about joining in group and community expression, communicating social values, participating in ritual (Hanna 1979).

3:2 Physiology & neuro-anatomy pathway of music

Music affects overall physiological processes of the human body. One of the very apparent physiological responses to music is a change in breathing or heart rate. Fast music can increase blood pressure, breathing rate, and heart rate and can result in reduced baroreflex sensitivity (Trappe 2012). Music with fast tempos increases the level of arousal and especially stimulates the level of attention (Trappe 2012). Music with slower tempos can significantly reduce heart rate and breathing frequency when compared to normal conditions (Trappe 2012). Slow music can reduce a physical and mental state of relaxation (Kim et al 2009).
Music triggers release of dopamine in dorsal and ventral striatum. Dopamine in the caudate fluctuates in anticipation of the desire or the favourite part of a song (Salimpoor et al 2011).

Neuroimaging studies have shown musical stimuli to activate specific pathways in several brain areas associated with emotional behaviours, such as the insular and cingulate cortex, hypothalamus, hippocampus, amygdala and pre-frontal cortex (Boso et al 2006). Neurochemical studies have suggested that several biochemical mediators such as endorphins, endocannabinoids, dopamine and nitric oxide may play a role in the musical experience (Boso et al 2006).

Music therapy could be effective in patients with neurodegenerative disorders such as Alzheimer’s Disease and Parkinson’s disease as well as in psychiatric illness such as schizophrenia, depression, anxiety and autism spectrum disorders (Boso et al 2006).

3.3 Physiotherapy for older adults
The role of physiotherapy in the care of mentally ill older people overlaps greatly with that of physiotherapy in general care of older adults and in that in psychiatry with younger patients, as well as in older people suffering from dementia (Tina et al 1995).

4.0 Methodology
An observation of two different types of strength and balance training with in-patients at an older person’s mental health unit. Both strength and balance training types were delivered with the use of music. Observations were taken of:
1. A Movement and Music class: for patients admitted to functional older adult ward
2. A Circle – Dancing class: for patients admitted to the Dementia Unit.

The venue for both classes was subject to a risk assessment prior to the classes starting each week. Staff supported patients to access the venue as required.

Music with a moderate intensity was selected to be played. Patient music preferences were considered and used. Facilitators led each session using non-verbal cues and demonstrated specific exercises for patients to mirror, from seated exercises to standing exercises.

For the Circle Dancing class, participants were arranged in circle. In addition to moderate intensity music, music was also selected to represent different cultural backgrounds. A facilitator led the session with non-verbal cues and demonstration of specific exercises for participants to mirror. The class also involved participants holding hands in dance in a pattern of movement led by participants or the staff/ facilitator.

5.0 Results
- The Movement and Music class was attended by an average of 6-10 patients once weekly.
- The Circle Dancing class was attended by 3-6 patients out of total possible 8 patients each week.
- Nine out of 10 patients from the functional ward engaged in music and movement. Six of the 9 also usually engaged in circle dance.
- Most often Circle Dancing ended with an individual participant going on to have a one to one session with a physiotherapist providing the opportunity for them to complete a patient baseline assessment or facilitate further balance treatment.
- One to two participants from the Dementia Unit responded to the music with only limited movement - active dorsiflexion/plantar flexion of their feet in seated position.
- The majority of participants displayed brightened facial expressions – this was particularly evident in the older adults with Dementia.
- Participants from the functional ward at the unit gave positive verbal feedback to staff and the facilitator at the end of the Movement and Music classes.

6.0 Discussion
6.1 Peer Discussion
The therapy team reported the following as the therapeutic effects of music with older adults admitted to the unit:
- It acts to increase respiratory muscle use through increased breathing rates secondary to increased movement – strengthening lung and abdominal muscles (especially when participants sing along)
- It promotes active range of movement in peripheral joints
• Improves circulation
• Cognitive stimulation
• Helps with balance training
• Promotes social interaction with staff and other participants
• It seemed to relieve stress and promote relaxation – likely through the means of reminiscence.

6.2 Personal observations
During the class, a participant was observed to sing as they engaged in individual safe indoor mobility, demonstrating the ability to dual task.
Another participant was observed to be entertaining others with song later that day, while all the in-patients were in the dining area at meal-time.

7.0 Conclusion
The place of music in clinical practice should not be underestimated. Music affects all age groups in different ways with different responses noted in individuals; however, dancing is a common positive consequence of music and since dance is a form of movement, more dancing is likely to have benefit for people who are not usually physically active. It is not clear from this observational study whether music therapy alone impacts on self-management ability for older adults with Dementia. More robust studies are needed if we are to fully understand the relationship between music, dance and physical activity in older people with mental health conditions, including Dementia. However, physiotherapists working with older adults with mental health conditions should explore the use of music and dancing when supporting this population to engage in therapeutic exercises either in the acute in-patient setting, or in the community (for example, as part of a maintenance and/or self-management regime).

Acknowledgements
Special thanks to Julie McGreal-Kyte and Leisl Haddon both therapy assistants in Forest Centre for their contribution to this article.
For further information please contact-Kolapo Jegede; Kolapo.jegede@nhft.nhs.uk

References
Adapted from NICE guideline on mental wellbeing in over 65’s: occupational therapy and physical activity interventions (2008). PH16, recommendation 2.
Music therapy and Older Adults (2005) copyright.
Managing the older person amputee: a community perspective

In association with BACPAR

British Association of Chartered Physiotherapists in Amputee Rehabilitation

Led by: Julia Earle, BACPAR Chair and supported by local BACPAR representatives

AGILE have collaborated with BACPAR to deliver a day of lectures and practical sessions in each AGILE region for physiotherapists to build and consolidate their knowledge when managing the older amputee. Particular emphasis will be to problem solve those that are difficult to manage – those that don’t fit the expected pathway, from a community perspective.

BACPAR will provide an overview on the reasons for amputations, levels of surgery and the wearing prosthetics – or not. Group work using a problem based approach will review phases of rehabilitation, treatment planning and additional referrals.

More detailed discussion will reflect
- Understanding basic prosthetics and gait deviations
- Pneumatic Post-Amputation Mobility (PPAM) aid/femurette use
- Transfers with/without limbs
- The contra-lateral foot
- Potential therapy constraints; Pain, oedema, dementia, the chronic amputee

£50.00 AGILE members;
£65.00 Non-members

Further information will be available via your regional rep and via AGILE communications

http://agile.csp.org.uk/network-events

<table>
<thead>
<tr>
<th>Region</th>
<th>Date</th>
<th>Venue</th>
<th>Organiser and correspondence address</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>22/4/17</td>
<td>Fred and Ann Green Rehabilitation Centre, Montagu Hospital, Adwick Road, Mexborough S64 0AZ, <strong>Doncaster</strong></td>
<td>Joanne Talaga <a href="mailto:Joanne.talaga@dbh.nhs.uk">Joanne.talaga@dbh.nhs.uk</a> Jill Taylor <a href="mailto:Jill.Taylor2@dbh.nhs.uk">Jill.Taylor2@dbh.nhs.uk</a></td>
</tr>
<tr>
<td>Ireland</td>
<td>13/5/17</td>
<td>Meadowlands Physio Dept. in the Musgrave Park Hospital, Belfast</td>
<td><a href="mailto:agile.northernireland@gmail.com">agile.northernireland@gmail.com</a> Gail McMillan</td>
</tr>
<tr>
<td>West</td>
<td>10/6/17</td>
<td>Inpatients Royal Southants Hospital, <strong>Southampton</strong></td>
<td><a href="mailto:agile.rep.west@gmail.com">agile.rep.west@gmail.com</a> Kate Bennett</td>
</tr>
<tr>
<td>East</td>
<td>9/7/17</td>
<td>ARU - Amputee Rehabilitation Unit, Lambeth Community Care Centre, Monkton Street, <strong>London</strong> SE11 4TX</td>
<td><a href="mailto:agileeast@gmail.com">agileeast@gmail.com</a> Claire Betts</td>
</tr>
<tr>
<td>Scotland</td>
<td>28/10/17</td>
<td>Amputee Gym, Ninewells Hospital, <strong>Dundee</strong></td>
<td><a href="mailto:agilescottishrep@gmail.com">agilescottishrep@gmail.com</a> David Hegarty</td>
</tr>
</tbody>
</table>

Full details on particular AGILE course via organiser or on AGILE website at  http://agile.csp.org.uk/network-events
Join the AGILE National Executive Committee

Would you like to:

- Be first to hear about new standards, study days and evening lectures?
- Extend your professional network for support and clinical advice?
- Improve your career prospects?
- Strengthen your CPD?
- Put across your viewpoint e.g. providing feedback on new projects, initiatives and research related physiotherapy for older people?
- Have the chance to organise a study day and get a free place?
- Build up contacts in other sectors e.g. Age UK?

AGILE Committees focus on improving practice whether through identifying or implementing guidelines, exercise programmes, standards, audits or study days. As a member, you decide how much you offer at any given time. If you’d like to know more, contact your Regional Representative and/or go along to a regional meeting to see what you think. Being part of an AGILE Regional Committee is not a huge commitment as meetings are only held two to four times per year. Travel expenses are paid.

For those of you interested in joining the National Executive Committee, the following vacancy exists: AGILE Public Relations Officer. Get in touch with the current post holder now to arrange shadowing.
Using benchmarking data to improve clinical practice and service provision in services for older people

Authors: Alison Cowley, Clinical Academic Physiotherapist and Louise Bramley, Clinical Academic Nurse, East Midlands Academic Health Science Network and Nottingham University Hospitals NHS Trust

Abstract

This article informs physiotherapists of the benefits and capabilities of service level benchmarks in identifying high-quality care, service variation and to inform service design and developments.

1.0 Background

The demands of an ageing population and increasing numbers of people with complex and multiple long-term conditions has led to a radical ‘rethink’ in how services are designed and provided within the NHS and wider health and social care community. The NHS Five Year Forward View (NHS England 2014) articulates the need to develop high quality services which support people with multiple health conditions and focuses on keeping older people living in their own homes or supportive care environments wherever possible. However, older people with one or multiple long-term conditions are more likely to need urgent care which often includes admission to hospital. In the last 10 years, emergency admissions of the over 65s have doubled, with people aged 85 years plus more than twice as likely to experience an unplanned admission (Morse 2013).

Older people account for more hospital admissions than younger people, having longer lengths of stay, occupying more bed days in acute hospital trusts, greater use of social care provision, higher readmission rates and frequently have poorer outcomes (Morse 2013; Banerjee et al 2012). Yet, over the last few years, there have been a number of high profile enquiries that have highlighted shortfalls and neglect in their care (Francis 2013; Parliamentary and Health Service Ombudsman 2015). These reports have stressed the importance of improvements to services in order to provide high-quality care to older people across health and social care.

Understanding how patients access services and the quality of care and support they receive is therefore essential towards informing service design and improvements. Benchmarking is one method that can help clinicians, service users and commissioners identify examples of high-quality care, share best practice, identify variation and inform service design and developments.

2.0 Service Level Benchmarking

“Benchmarking is the use of structured comparisons to help define and implement best practice.” (NHS Benchmarking Network 2016a). It can help therapy teams understand the quality of the service they provide patients through routinely measuring and benchmarking their performance with peers across the three dimensions of quality – safety, effectiveness and patient experience (The National Quality Board 2013).

The NHS Benchmarking Network (NHSBN) was founded in 1996 and is the in-house benchmarking service of the NHS. They have strong links to national bodies including NHS Improvement, the Patients Association, Department of Health and the Chartered Society of Physiotherapy and currently support 330 organisations across the United Kingdom, who subscribe to the network to participate in benchmarking activities.

In response to pressures across secondary care and an ageing population, the Older People’s Care in Acute Settings benchmark was launched in 2014. This benchmark, focuses on four aspects of the acute pathway; admission avoidance in accident and emergency, assessment units, inpatient wards and supported discharge. The benchmark collects high level service data on models of care delivery, activity, finance, workforce, quality, outcomes and service user experience of an episode of care (NHSBN 2016a). None of the indicators throughout the benchmark seek to gather patient identifiable data. In 2015, 49 participating services from Trusts and Local Health Boards (LHBs) in England and Wales submitted data (NHSBN 2016b). Results from this benchmark were made available on-line and allow subscribers to compare their service nationally across hundreds.
of metrics. Subscribers also receive a local bespoke report which summarises key messages and metrics for their organisation, highlighting participants’ own position and results against national averages. This allows for areas of improvement to be identified or best practice to be shared across the wider health community.

3.0 Clinical Implications - How can clinical physiotherapists use this data?

Benchmark data from the older people’s acute care benchmark, offers frontline clinical staff the opportunity to review current practice and service provision. The first step to using this data to make meaningful improvements to practice is to identify if your organisation has taken part in the benchmark and request a copy of the report from your head of service and divisional leaders.

Reviewing the whole data set and metrics can be a daunting task but the best place to start is with a specific clinical question, concern or observation which will help you navigate the data. For example, you may be concerned that your department’s skill mix or establishment numbers do not meet the requirements of your patient acuity or complexity. You can then locate specific metrics around skill mix (see figure 1) and costs per admission to assessment units (figure 2) and compare your data to national averages.

This has been particularly useful in building evidence-based business cases for therapy provision in frailty assessment units and to inform discussions with colleagues or service leads to challenge existing practice. By collating benchmark data across services provided within acute hospitals, allied health professionals’ skill mix can be viewed across the acute patient pathway. This can be seen in table 1, which demonstrates that a lower skill mix is found on care of older people wards, with greater numbers of band 2 and 3 staff compared to band 6 and 7s. Whereas admission avoidance teams based in accident and emergency frequently have establishments with higher staff bands, reflecting the acuity of their workload. Comparable data is also available for nursing and medical staffing.

<table>
<thead>
<tr>
<th>Band 2</th>
<th>Band 3</th>
<th>Band 4</th>
<th>Band 5</th>
<th>Band 6</th>
<th>Band 7</th>
<th>Band 8a</th>
<th>Band 8b</th>
<th>Band 8c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions avoidance in A&amp;E</td>
<td>0%</td>
<td>6%</td>
<td>7%</td>
<td>19%</td>
<td>51%</td>
<td>16%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Assessment units</td>
<td>2%</td>
<td>10%</td>
<td>6%</td>
<td>20%</td>
<td>46%</td>
<td>16%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Care of older people wards</td>
<td>6%</td>
<td>14%</td>
<td>6%</td>
<td>31%</td>
<td>28%</td>
<td>15%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Supported discharge team</td>
<td>0%</td>
<td>17%</td>
<td>17%</td>
<td>1%</td>
<td>44%</td>
<td>15%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Table 1 – Allied Health Professional skill mix across the acute hospital setting
The benchmark also reports on variations relating to patient safety and quality of care. For example, the metrics ask specific questions on the incidence of falls and incorporates a comprehensive service user audit. Whilst many of these metrics are collected as part of local governance programmes, the older person’s acute care benchmark allows your organisation’s data to be benchmarked against comparable organisations and provides you with robust data to support service improvement initiatives or business cases to improve quality care that patients receive. This method of collecting benchmarking data year on year also allows organisations and services to understand how local changes have impacted the system and patients’ satisfaction and care.

3.1 Comprehensive Geriatric Assessment

The benchmark also explores specific models of care, such as Comprehensive Geriatric Assessment (CGA). CGA has consistently been shown through high quality research to deliver measurable health improvements for older people living with frailty (Welsh et al 2014) in the acute care setting. Many trusts already provide CGA models of care, but some organisations are exploring how this model can be adopted and implemented to best suit their specific patient population. Table 2 shows an example of how one individual trust compares to the national picture. Benchmark metrics can give physiotherapists the evidence they need to support and drive through the implementation process. It can also highlight areas of good practice when a trust is doing well.

The Older People’s Care in Acute Settings benchmark will run again in 2017 along with the National Audit of Intermediate Care which looks at four service categories: crisis response, home based intermediate care, bed based intermediate care and re-ablement services. In addition to this, in 2014 an Acute Therapies benchmark was developed which explores the four disciplines of physiotherapy, occupational therapy, dietetics and speech & language therapy service provision within the acute setting. Although not specific to services for older people, this benchmark, completed in 2014/15 was well received by network members and will run again in 2017/18, providing clinicians with a robust tool to understand and review current acute provision.

4.0 Conclusion

Benchmarking is a valuable tool for collecting data on services for older people in acute and community

<table>
<thead>
<tr>
<th>Does CGA take place – yes/no?</th>
<th>E.g. of individual trust (anonymous)</th>
<th>National report</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the frailty unit?</td>
<td>67%</td>
<td>86%</td>
</tr>
<tr>
<td>In the short-term assessment unit?</td>
<td>43%</td>
<td>53%</td>
</tr>
<tr>
<td>In other assessment unit?</td>
<td>78%</td>
<td>60%</td>
</tr>
<tr>
<td>On care of the older people’s wards?</td>
<td>75%</td>
<td>86%</td>
</tr>
<tr>
<td>On other speciality wards?</td>
<td>11%</td>
<td>30%</td>
</tr>
<tr>
<td>Is there an awareness programme of non-geriatricians about frailty and CGA?</td>
<td>22%</td>
<td>26%</td>
</tr>
<tr>
<td>Can CGA be accessed in the community?</td>
<td>78%</td>
<td>65%</td>
</tr>
<tr>
<td>Is CGA documented on a shared assessment accessed by all members of the MDT?</td>
<td>56%</td>
<td>49%</td>
</tr>
<tr>
<td>Do CGA’s contain a care plan discussed with the patient/carer?</td>
<td>44%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Table 2 – Comprehensive Geriatric Assessment models of care

services. This allows services to benchmark themselves to other comparable trusts and develop robust action plans to drive quality through targeting service improvements and initiatives to improve care, patient and staff experience and outcomes. The main strength of benchmark is that it provides robust data, collected over time, which in turn can facilitate conversations between clinicians, managers and commissioners allowing practice to be challenged and improved.

Acknowledgements

For further information please contact Alison Cowley at alison.cowley@nuh.nhs.uk.
References


Parliamentary and Health Service Ombudsman (2105) Dying Without Dignity: Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care. Parliamentary and Health Service Ombudsman: London.


1.0 Introduction

The number of emergency hospital admissions in Scotland of individuals aged 65 and over has increased by 26% since 2005 (SD Scotland 2015). New models of care stress the importance of community-based provision for older people (Scottish Government 2009), but inevitably there will be instances when a hospital admission is indicated. Against the backdrop of demographic challenges, service delivery models on acute Care of the Elderly (CoE) wards are under pressure to deliver timely discharge, avoid unnecessary (re)admissions and use available human recourses efficiently.

There is surprisingly little research evidence on different ways of organising physiotherapy provision for older people in the acute medical setting. Researchers have mapped physiotherapy service delivery models in intensive care (Fisher et al 2012; Jones et al 2015) and looked at specific physiotherapy service redesign interventions, for example the introduction of physiotherapy triaging roles (Hussenbux et al 2015). Specific guidelines also exist around recommended patient to therapist ratios in intensive care (Valentin and Ferdinande 2011) and stroke rehab (McHugh and Swain 2014). However, there has been little research on service delivery models of physiotherapy targeting older people on acute medical wards. This is problematic given the clear demand for evidence in this area among physiotherapists: the online discussion forum of the Chartered Society of Physiotherapy (CSP) has played host to multiple requests for benchmarks around how acute CoE physiotherapy teams prioritise caseloads, structure the referral pathway to reduce inappropriate referrals, determine safe staffing ratios and, to a lesser extent, agree key performance indicators for their service.

The primary aim of this study was to map models of physiotherapy service delivery currently in place on CoE wards in large acute hospitals across Scotland. A secondary aim was to explore how well current service delivery models fit with good practice principles. For example, the literature on managing effective healthcare teams stresses the importance of clear objectives, well-defined operational procedures and a performance measurement framework that is fit for purpose (Nancarrow et al 2013; Storey and Holti 2013; Borrill et al 2000). Anecdotal evidence suggests that these may not be universal features across acute CoE physiotherapy services. We expected that most physiotherapy service provision in Scottish acute CoE wards would be run without specific objectives, standard operating procedures (e.g. written referral criteria, written caseload prioritisation systems) or outcome measurement systems in place. In addition, we wanted to explore whether the presence of a dedicated (stand-alone) CoE team, clinical input in the team from a Physiotherapy Team Manager and lower caseloads per physiotherapist were linked to CoE physiotherapy provision that was “better” organised, i.e. more likely to involve standard operating procedures or outcome measurement systems.

2.0 Method

2.1 Inclusion criteria

All acute Scottish NHS hospitals with 500 beds or more, or the largest with acute inpatient CoE services (for Boards without a hospital with 500 beds or more), were included. The leaders of the teams providing physiotherapy services on CoE wards in these hospitals were targeted.

2.2 Exclusion criteria

Rehabilitation wards, day hospitals, outpatient and community physiotherapy services for the elderly were excluded.

2.3 Recruitment of participants

Letters were sent to the physiotherapy service managers. Service managers who did not respond to this initial letter were contacted by email or phone. Service managers were invited to provide contact details for the CoE physiotherapy team leads. These team leads were then contacted by phone, informed about the study and asked for their consent to participate.
2.4 Data collection and analysis
Telephone interviews were organised on the basis of a topic guide. All interviews were written up immediately after the interview. The data was analysed thematically.

2.5 Ethics approval
The NHS Tayside Research and Development Office were informed about the study. This was a service evaluation that did not require ethical approval, according to UK Research Ethics Committee guidelines.

3.0 Results
Seventeen hospitals met the selection criteria; 13 interviews took place. The team leads of the four remaining hospitals could not be contacted despite repeated attempts. The results from one interview were discarded because the hospital did not operate a separate CoE ward.

3.1 Referral pathways
Half of the hospitals surveyed (six of 12) operated a blanket referral, i.e. all new patients on acute CoE wards were screened or assessed by a physiotherapist. Where no blanket referral was in operation, between 60-70% and 90% of new patients were referred, mostly by medical or nursing staff. Referral criteria typically did not exist in any formal or written format. Only one interviewee reported the existence of formalised referral criteria and a referral flowchart. Otherwise, the referral to physiotherapy was the result of a brief discussion between the physiotherapist and another member of the multidisciplinary team. One interviewee mentioned the (optional) use of a written referral card. One hospital operated a generic allied health professions (AHP) referral pathway as opposed to a separate physiotherapy pathway: nursing staff referred to either a physiotherapist or an occupational therapist (OT); the therapist then used an AHP screening tool to triage the patient to physiotherapy or OT.

3.2 Team and staffing structure
Just over half of the hospitals (seven of 12) had a stand-alone CoE therapy team, with a dedicated CoE team lead. In three cases, this was an AHP team, covering both physiotherapy and OT; in four cases this was a physiotherapy-only team. In the remaining five hospitals, there was no stand-alone CoE team. In three of these hospitals, the CoE physiotherapy team also covered stroke; in two hospitals, the CoE team also covered a number of other, mainly medical, wards.

All but one of the hospitals employed junior physiotherapists (band 5 Agenda for Change (AfC) equivalent), typically rotational, on their acute CoE wards. All but three hospitals employed specialist physiotherapists (band 6), typically static. There was clinical physiotherapy team manager (band 7) involvement in only three hospitals. All teams had access to physiotherapy support workers.

The average ratio of junior (band 5) to more senior staff was 1.33 whole time equivalent (WTE) junior to one more senior physiotherapist. The average ratio of support workers to physiotherapy staff was 0.61.

<table>
<thead>
<tr>
<th>Job title</th>
<th>Population NHS Board area (1,000s)</th>
<th>Acute inpatient CoE beds in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
<td>400 - 750</td>
<td>20-50</td>
</tr>
<tr>
<td>Physiotherapy Team Manager</td>
<td>100 - 400</td>
<td>20-50</td>
</tr>
<tr>
<td>Physiotherapy Team Manager</td>
<td>400 - 750</td>
<td>50-90</td>
</tr>
<tr>
<td>Specialist Physiotherapist</td>
<td>100 - 400</td>
<td>20-50</td>
</tr>
<tr>
<td>AHP Team Leader</td>
<td>&gt; 750</td>
<td>90-150</td>
</tr>
<tr>
<td>Physiotherapy Team Manager</td>
<td>&gt; 750</td>
<td>20-50</td>
</tr>
<tr>
<td>Physiotherapy Team Manager</td>
<td>&gt; 750</td>
<td>90-150</td>
</tr>
<tr>
<td>Physiotherapy Manager</td>
<td>400 - 750</td>
<td>50-90</td>
</tr>
<tr>
<td>Specialist Physiotherapist</td>
<td>100 - 400</td>
<td>90-150</td>
</tr>
<tr>
<td>Specialist Physiotherapist</td>
<td>400 - 750</td>
<td>50</td>
</tr>
<tr>
<td>Specialist Physiotherapist</td>
<td>100 - 400</td>
<td>50</td>
</tr>
<tr>
<td>Specialist Physiotherapist</td>
<td>&gt; 750</td>
<td>90-150</td>
</tr>
</tbody>
</table>

Table 1. Participants – job title, board and hospital data
3.3 Bed to physiotherapist ratios and prioritisation

Most hospitals (eighth out of 10) had a bed to physiotherapist ratio of between 25 and 32 beds per physiotherapist. The remaining two hospitals had 20 and 40 beds per physiotherapist respectively. The average bed to physiotherapist ratio was 28. When taking into account the full staffing mix (physiotherapists and support workers), the lowest ratio was 14 beds per member of staff; the highest ratio 24 beds per member of staff. The average bed ratio was 19.

All physiotherapy services on acute CoE wards operated a prioritisation system. Acutely unwell chest patients, new patients and patients with their discharge pending were the main priorities across all hospitals. One hospital also prioritised a category of ‘up and outers’. These were patients who were likely to be fit for discharge soon after their initial admission on the ward. Priority patients were (to be) seen daily across all 12 participating hospitals.

A formal (coded) prioritisation system was in operation in five hospitals. Coding systems worked either on the basis of the number of days to anticipated discharge or the number of times per week physiotherapy input was required.

<table>
<thead>
<tr>
<th>Dedicated CoE team or not?</th>
<th>All</th>
<th>Dedicated CoE team</th>
<th>Combined team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff mix (physio only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Band 2 involvement</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Band 3 involvement</td>
<td>11</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Band 4 involvement</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Band 5 involvement</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Band 6 involvement</td>
<td>8</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Band 7 involvement</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Most senior clinical physiotherapy input</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Band 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Band 6</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Band 7</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Band 7</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 2. Number of hospitals with selected skill mix characteristics

Note: The five CoE teams that are combined with other specialties include three combined CoE and stroke teams and two combined CoE and medical teams.

<table>
<thead>
<tr>
<th>No of beds per WTE physiotherapist</th>
<th>No of beds per WTE member of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td>25.0 n/a</td>
</tr>
<tr>
<td>Hospital 2</td>
<td>31.8 23.0</td>
</tr>
<tr>
<td>Hospital 3</td>
<td>25.0 18.8</td>
</tr>
<tr>
<td>Hospital 4</td>
<td>19.6 n/a</td>
</tr>
<tr>
<td>Hospital 5</td>
<td>24.5 15.1</td>
</tr>
<tr>
<td>Hospital 6</td>
<td>40.0 24.0</td>
</tr>
<tr>
<td>Hospital 7</td>
<td>32.0 19.2</td>
</tr>
<tr>
<td>Hospital 8</td>
<td>25.0 22.7</td>
</tr>
<tr>
<td>Hospital 9</td>
<td>25.3 17.7</td>
</tr>
<tr>
<td>Hospital 10</td>
<td>30.0 14.4</td>
</tr>
<tr>
<td>Average</td>
<td>27.8 19.4</td>
</tr>
</tbody>
</table>

Table 3. Bed ratios

3.4 Standards and performance management

All teams included in this mapping recorded statistical information. The detail of what was collected varied but tended to be limited to physiotherapy input variables, in line with ISD requirements, for example...
the number of patients, time spent per patient, and, less frequently, an indicator of the complexity of the patient’s presentation and the number of unmet needs. None of the participating hospitals tracked physiotherapy outputs or outcomes across the service as a whole (outcome data was included in the physiotherapy notes of individual patients).

All acute CoE teams (for whom this information was available) worked towards a standard of seeing new patients within a fixed timeframe, typically 24 hours, one working day or 48 hours. Only one health board area reported CoE-specific standard operating procedures and a ‘service descriptor’ setting out the standards of care the physiotherapy service was aiming to achieve in its acute CoE provision. Another team reported that they were working towards the Standard of Care for Dementia in Scotland. Teams also reported compliance with generic professional physiotherapy standards.

4.0 Discussion

It is possible, on the basis of the results of the mapping exercise, to set out the physiotherapy service delivery model on a ‘typical’ acute CoE ward in Scotland. This model sees one qualified physiotherapist per CoE ward, covering about 28 beds, supported by a 0.6 WTE physiotherapy support worker. Typically, there is a stand-alone CoE therapy team, which may also include OTs, and a dedicated CoE team lead. The team includes a mix of rotational junior physiotherapists and static specialist physiotherapists, with 1.33 WTE junior physiotherapists to each specialist physiotherapist. Referral pathways to physiotherapy are typically informal and verbal with the vast majority (60-100%) of patients referred for physiotherapy. The service operates an informal caseload prioritisation system. The service monitors its own activity levels, but does not track outcome data across the service as a whole. The service works towards a standard of seeing all new patients within one working day of referral; there are no other team standards or objectives in place.

Staffing levels from our study can be compared to data available from previous research, but only to an extent. Cartmill et al (2012) reviewed the research evidence on AHP staffing levels (bed ratios) and pointed to the lack of relevant data in general hospital settings. In an older study (Squires and Hastings 1997), physiotherapists themselves recommended the equivalent of 19 beds per WTE physiotherapist – a lower ratio than the 28 beds per physiotherapist noted in our mapping exercise. A 2004 nationwide survey of Canadian hospital services, reported by Burnet and Klaiman (2009) noted an average bed to physiotherapist ratio of 25, again lower than the ratio in our study. The Canadian study remarked that it was unclear whether bed ratios reflected genuine patient need or were a reflection of the funds available to the hospital. The same applies to the Scottish evidence. In the UK, guidelines on safe staffing levels for nursing in acute hospitals (NICE 2014) explicitly avoid a single nursing staff to patient ratio. The CSP has similarly cautioned against too narrow a focus on staffing levels (CSP 2014).

In our mapping exercise, bed ratios varied significantly: the ‘busiest’ physiotherapist (40 beds) was responsible for twice as many beds as the ‘least busy’ physiotherapist (20). However, these two bed ratios were outliers. Bed ratios in other hospitals fell between 25 and 32 beds per physiotherapist. In addition, the staff mix appeared to suggest an explanation for the seemingly extreme variation: the four hospitals with higher (30-40) bed to physiotherapist ratios all had either clinical band 7 physiotherapist input or markedly higher support worker input (just more than one WTE support worker for each physiotherapist). There appear to be three different human resource strategies in play across acute CoE wards in Scotland: (i) opting for fewer staff but including more senior (band 7) clinical input; (ii) opting for a high (1:1) support worker to qualified staff ratio; (iii) working with a ‘typical’ staff mix of junior (band 5) and specialist (band 6) physiotherapists with an average (0.6 to one) support worker to physiotherapist ratio. At this point in time, there is no evidence to suggest that one strategy is more effective or more cost-effective than another. However, clinical band 7 physiotherapist input may come at the cost of not having a stand-alone CoE team, as was the case for two of the three teams with clinical band 7 input in our sample. The possible implications of not having a dedicated CoE team are discussed later in this article.

Developing recommendations with regard to the skills mix is similarly fraught with challenges. Dixon et al (2010) looked at the impact of the healthcare staff skills mix costs and outcomes in intermediate care services and found that overall the impact of the service skill mix on costs and outcomes was limited. It may be that investing in design of processes (clinical pathways, care descriptors and standard operating procedures) may be of more importance to outcomes than the precise staff mix. A recent English and Welsh bench-marking exercise (NHS Benchmarking Network 2016) reported on the AHP skills mix on acute CoE wards: band 5s (31%) and band 6s (28%) made up the majority of AHP staff on these wards, followed by band 7s (15%) and band 3s (14%). The band 5/6...
majority is in line with the findings of our mapping exercise. The proportion of support workers (25%) to physiotherapists (75%) in the English and Welsh survey appears lower than the data for Scotland (0.61 WTE support staff per one WTE qualified staff), but different methodologies mean no direct comparison is possible.

The hypothesis that most physiotherapy service provision in acute CoE wards would be run without formalised objectives, standard operating procedures or performance management systems in place was largely (not fully) confirmed in the mapping exercise. Team leads almost unanimously reported as their only standard that new patients were to be seen within a certain time frame. Service performance management tended to focus on statutory recording of physiotherapy inputs, with however one team reporting plans for a patient satisfaction questionnaire. The picture was more mixed in terms of the presence of agreed and formalised procedures, with examples of written referral criteria, a formal AHP screening tool, in one instance full standard operating procedures for the CoE physiotherapy service and several hospitals reporting formalised, coded prioritisation systems.

There was no evidence that teams with lower bed to physiotherapist ratios or teams with more senior staff involvement were more likely to operate with stronger (formalised) procedures or performance management systems. For example, the patient satisfaction questionnaire was being developed in the hospital with the highest bed to qualified physiotherapist ratio of the 12 hospitals; the CoE physiotherapy ‘care descriptor’ was reported by a team that had no band 7 input. However, stand-alone CoE teams were more likely to report examples of more ‘organised’ CoE provision: the care descriptor and standard operating procedures, the AHP referral screening tool, and additionally, an example of all team members being involved in CoE research, references to compliance with the Dementia standard and dedicated dementia and vestibular training were all mentioned in the context of dedicated CoE teams.

5.0 Conclusion
Overall, there appears to be some scope to enhance models of physiotherapy service delivery on CoE wards. Hospitals from our study point to some potentially good practice examples that can help inform practice. Physiotherapy managers may want to work towards a model of service delivery that includes a dedicated CoE therapy team with a dedicated CoE team lead, a CoE physiotherapy ‘care descriptor’ setting out minimum quality care standards, CoE physiotherapy standard operating procedures, formal referral criteria and a formal and coded prioritisation system.

Acknowledgements
The author wishes to acknowledge the financial support received from AGILE, the Chartered Society of Physiotherapists’ network of physiotherapists working with older people and the support provided by the NHS Tayside Physiotherapy Department (Dundee), where the author is based. Finally, the author wishes to thank the 13 hospitals and therapists who participated in this research.

References
Professionals involved in the world of moving and handling regularly face the various challenges seen every day in this field. All agree that within this remit, self-care is crucial for the person’s wellbeing, independence and to reduce the risk of immobility acquired conditions and it can be complex to achieve a balance between this and safety of the carer. Therapists are often relied upon to develop handling solutions that meet the needs of both and can find themselves looking for advice and support outside of their own organisation.

National Back Exchange (NBE) is a professional association that exists to develop, disseminate and promote evidence based best practice in all aspects of moving and handling. Initially founded nearly thirty years ago – the association has gone from strength to strength. Our current membership stands at over one thousand professionals who are dedicated to ensuring excellence in this field for the benefit of the patient and the carer.

Members can join their local branch of NBE which will meet periodically throughout the year. This provides a perfect arena for multidisciplinary professionals, including physios, occupational therapists, nurses, ergonomists, advisors and academics involved in moving and handling to meet together, discuss challenging situations and share best practice. This includes all those working within health, education and social care in acute, community and private settings. Our members also make use of the various social media platforms provided and the website forums, to seek solutions to complex handling cases.

This sharing of best practice makes for a rich source of information, evidence and expertise. Solution focussed risk assessment, promoting mobility and providing excellent standards of care are forefront in our field, whilst ensuring carer safety.

The association has produced numerous publications, written by experts in their field which provide an evidence base and guide professionals in specific areas of moving and handling.

NBE are recognised internationally and provide representation on the editorial board of the new International Journal of Safe Patient Handling and Mobility (formerly the American Journal SPHM). We have negotiated preferential subscription rates for our members and our involvement is a huge step in staking our claim in the international field as a body of expertise, demonstrating that we are respected for this. The journal provides an academic platform for associations around the world to share research and evidence based practice. This is the foundation to a solid relationship that has many exciting opportunities ahead for us in terms of working collaboratively with other international associations. We will be developing a mentorship programme to assist our members to publish in the journal at an academic level.

Our highly popular annual conference, held in September, is attended not only by members but also external delegates and attracts an attendance of several hundred. The action packed, three day CPD event features strategic plenary sessions, practical and theoretical workshops and a large equipment exhibition. It is a ‘must attend’ learning opportunity and is the only conference of its kind.

We are also in the process of developing additional learning events and master classes which will deep dive into specific areas of moving and handling to meet the educational needs of our diverse membership.

NBE have a regular presence throughout the year at key conferences and events and members are often involved in the programmes, presenting various sessions. We have a professional affairs committee dedicated to identifying collaborative working opportunities with key stakeholders and influential bodies such as the Care Quality Commission, Health and Safety Executive and Health Education England. We are also about to launch our revised Professional Standards which aim to shape the future of the moving and handling professional and ensure their importance is recognised.

So, if you recognise the benefits of being part of our leading association and want to work with us to make a difference in moving and handling practice, please visit our website: www.nationalbackexchange.org or email our office at: admin@nationalbackexchange.org
Join AGILE

Membership is open to all CSP members who have an interest in the well-being of older people including other Allied Health Professionals e.g. Occupational Therapists who can join as an Associate Member

Membership categories:

**INDIVIDUAL**
Open to anyone who is a fully subscribing member of the Chartered Society of Physiotherapy. All UK practicing physiotherapists must be HCPC registered.

**GROUP**
Group membership can be offered to sites with rotational staff. On payment of the fee the department shall be entitled to one copy of AGILITY and subsidy on AGILE merchandise. Each group is entitled to one discounted fee at AGILE courses/conferences and one vote as required, providing that the course/conference/voting delegate is a CSP member.

**ASSOCIATE**
- Open to members of a profession allied to physiotherapy. This will be open to other professionals at the discretion of the Executive Committee. Such professionals must be members of an equivalent health or professional body.
- Overseas membership is available to any physiotherapist working overseas. Overseas members must be a member of their country’s physiotherapy governing body.

**ASSISTANT/STUDENT** *application via paper method*
Open to all physiotherapy undergraduates and to those in full time post-graduate study in physiotherapy. Also open to unemployed new physiotherapy graduates. Application via paper method.

**HONORARY**
This is conferred by the National Executive Committee to an individual in recognition for their work by AGILE.

---

**Membership Fees 2017: Still no price increase for membership!**

<table>
<thead>
<tr>
<th>Membership Type</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>£25</td>
</tr>
<tr>
<td>Group</td>
<td>£30</td>
</tr>
<tr>
<td>Associate</td>
<td>£25</td>
</tr>
<tr>
<td>Assistant/Student</td>
<td>£5 (CSP membership is a pre-requisite)</td>
</tr>
</tbody>
</table>

We have introduced Online Membership Renewal.

Joining online gives a year’s membership from point of joining, compared to the paper method which is Jan – Dec.

The new online feature uses a Direct Debit based system called Go Cardless. It is quick and easy to use and will mean that you no longer have to complete a paper application form and send in a cheque. It will also provide you with the standard protections applied to all payments of this type which come under the Direct Debit Guarantee scheme.

However the paper membership renewal service is still available.

Please go to the website for further instructions and to download the paper membership renewal form: www.agile.csp.org.uk/join-us
AGILE MEMBERSHIP APPLICATION FORM 2017
Chartered Physiotherapists working with Older People

Renewal form should be completed annually and sent with the membership fee to ensure that details are up to date unless completing process on-line.

PLEASE COMPLETE ALL APPROPRIATE FIELDS

CSP Member: Yes / No  CSP number:  AGILE Number:  
Title  First Name  Surname  
Group Name (where applicable)  
E-mail address  For distribution of information 
Preferred Mailing Address including postcode (please write in capital letters) 

New Member  Membership Renewal  Lapsed Member  Honorary Member  

REGIONAL GROUP

North  West  East  
Northern Ireland  Wales  Scotland  Overseas*  

MEMBERSHIP FEES for joining full or part-way through the year

Group £30  Individual £25**  Associate £25  Assistant/Student £5***  Other e.g. Honorary  

Cheques should be made payable to 'AGILE' and sent with this application
form to: Martina McGovern, Physiotherapy Department, Belfast City Hospital, Lisburn Road, Belfast BT9 7AB
Cheque Enclosed £ 

Please visit the AGILE website at – http://agile.csp.org.uk/join-us
to join by direct debit and speed up the renewal process.

* Welsh & Overseas Members please choose a region for regular updates on activities
** please attach membership of professional body
*** please attach details of full time study

OFFICE USE ONLY

Stage  Renewal processed  Cheque Forwarded to National Treasurer
Date  
Initials  

DATA PROTECTION ACT: Members' details are held on a computer database. Questionnaires may be sent by students undertaking dissertations – this will be via the membership secretary. The database address list may also be provided to a third party if the National Executive believe it would be beneficial to members' interest in older people. Please write to the membership secretary if you do not want your details disclosed in either of these circumstances.
The British Geriatrics Society is the professional body of specialists in the health care of older people in the United Kingdom.

Members include consultant geriatricians, nurses, GPs, allied health professionals and many others involved in the healthcare of older people.

Physiotherapists and occupational therapists form an active and growing part of the BGS multidisciplinary membership, accessing a range of professional support and benefits which include:

- A number of grants open to physiotherapists and occupational therapists at all stages of their career; grants can assist with attendance at conferences, or in visiting innovative services relevant to the special needs of older patients.
- Discounted attendance at BGS multi-disciplinary meetings, featuring tailored CPD content on subjects including bone health, dementia, falls and community geriatrics.
- Print and online subscription to *Age and Ageing*, the Society’s medical journal, offering access to cutting-edge research and editorial content; save over £285 compared to the standard cover price.
- Networking and professional development opportunities amongst the BGS’s expert and multidisciplinary membership, including our influential Special Interest Groups, providing expertise on disorder-specific issues and a specialist forum for therapist and nurse members
- Membership starts at only £48 annually for physiotherapists and occupational therapists. Existing members can save a further £20 when renewing by Direct Debit.

Joining the BGS, getting involved with their Falls and Bone Health SIG and becoming their first non-medical Chair has opened numerous doors for me, from working with NICE to national guideline development, which wouldn’t have happened otherwise.

Vicki Goodwin,
Physiotherapist

How to join

The BGS offers two tiers of membership for physiotherapists and occupational therapists.

Our standard subscription includes all of our main member benefits at only £48 for the first year (£28 for subsequent years when paying by Direct Debit). Our enhanced membership adds a full print and online subscription to our influential *Age & Ageing* journal, worth £350. This tier of membership costs just £98 for the first year (£78 for subsequent years) when paying by Direct Debit.

You can join the BGS either by phone, email or online:

Call us on 020 7608 1369
email membership@bgs.org.uk to discuss joining, or visit http://www.bgs.org.uk/joinBGS

Find out what the UK’s biggest specialist society can offer physiotherapists and occupational therapists