

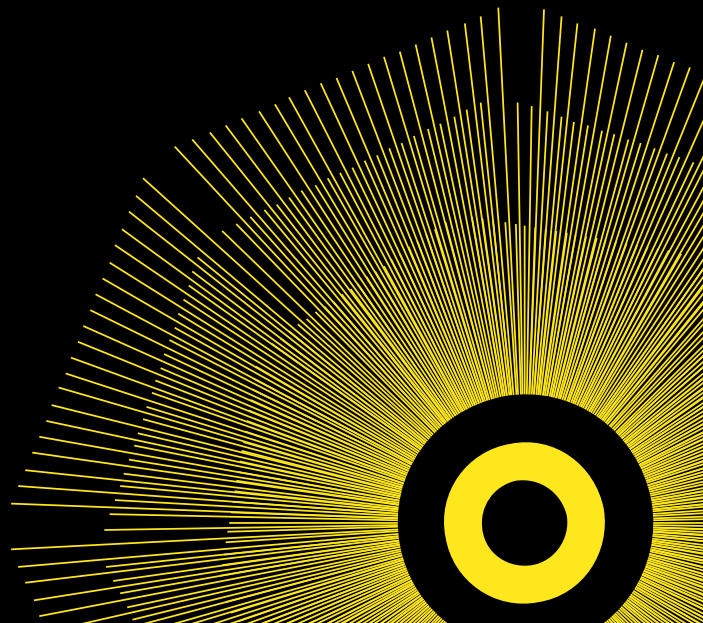
Shine 2014 final report

Assessing the impact of transferring the first point of contact within physiotherapy for Low Back Pain (LBP) patients to a fast tracked group intervention

Cardiff & Vale UHB

September 2015

The Health Foundation
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Part 1: Abstract

Project title: Assessing the impact of transferring the first point of contact within physiotherapy for Low Back Pain (LBP) patients to a fast tracked group intervention

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Abstract

Low Back Pain (LBP) has a significant personal, social and economic impact. It has been estimated that its cost to the NHS alone is £4.2 billion a year (ARMA 2012). The prevalence of LBP within society is also growing, with an increase of 6.3% between 1992 and 2006 (Freburger et al 2009). Therefore, this demands healthcare services are innovative and efficacious in their approach to managing this epidemic.

Research has highlighted the importance of a biopsychosocial approach to ensuring people with low back pain (PLBP) are at the centre of management decisions, by addressing unhelpful beliefs and enhancing their activation (Darlow et al, 2012; Overmeer et al 2011). The novel Manage Backs (MB) model was designed through transformative co-production to integrate these findings into primary care, changing the entry point on the care pathway from traditional 1:1 physiotherapy to a Group Intervention (GI), facilitated by a physiotherapist.

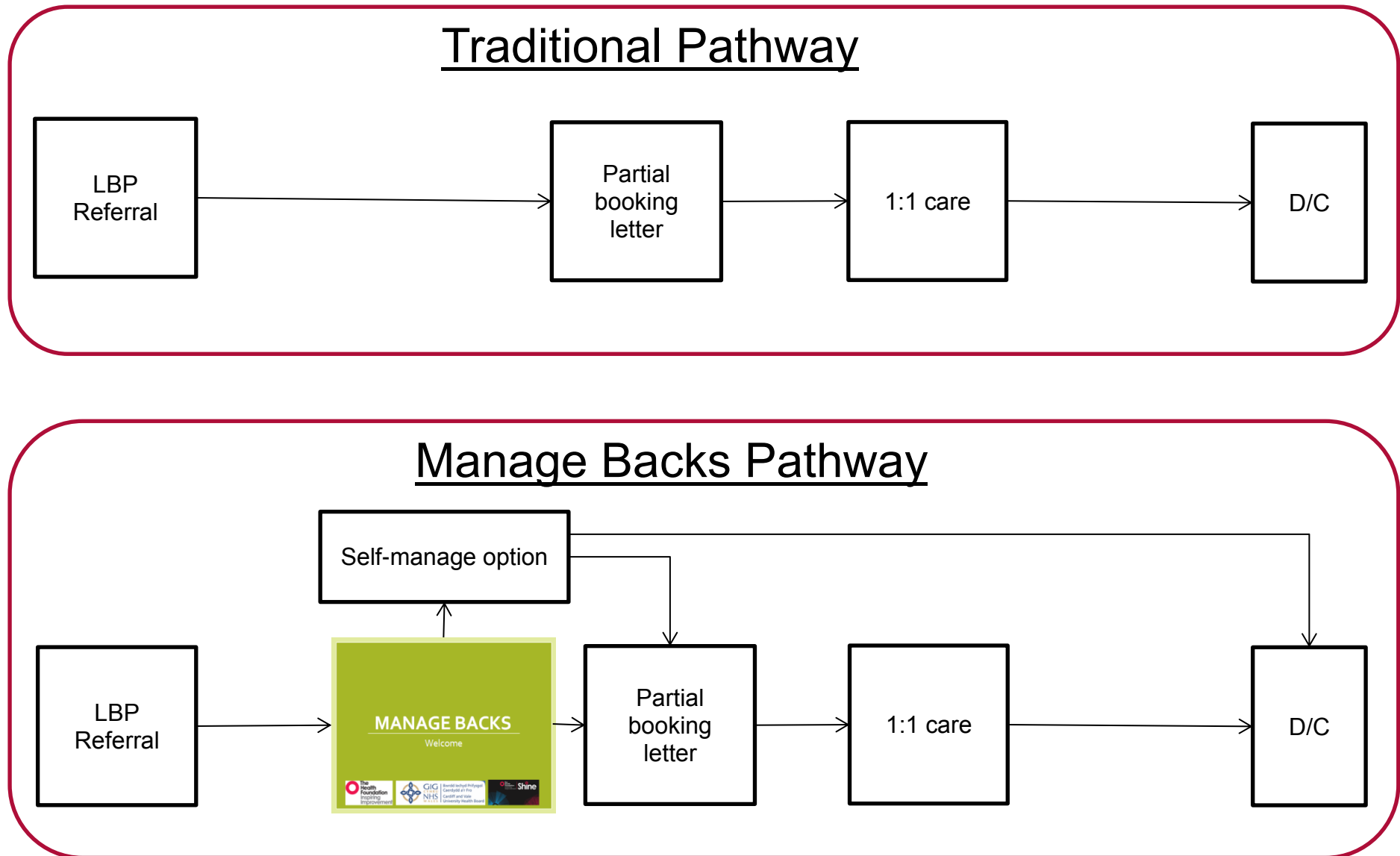
MB was delivered at 6 locality hospitals across Cardiff & Vale UHB, with over 600 PLBP attending a GI. The project aims were to provide PLBP with the knowledge and understanding to engage effectively in decisions and self-management strategies. In order to support this heightened engagement it was vital to enhance the GI physiotherapists' attitudes and beliefs. A biopsychosocially informed training and mentoring programme was developed and delivered to support this change. Additionally the potential to reduce wasted healthcare resources was examined.

The project's findings clearly demonstrate that MB has gained wide stakeholder acceptance on the primary care LBP management pathway. The outcomes demonstrated improvements in both the physiotherapists' confidence to deliver the GI and a shift in beliefs toward a biopsychosocial focus. There was also a clear impact of the MB model on wasted healthcare resources, with potential pathway delivery cost savings of up to 28% identified. The usefulness of the GI to support PLBP to engage in decisions and self-management strategies has been demonstrated both qualitatively and quantitatively. This heightened confidence has enabled 13% of those PLBP attending a GI to opt to self-manage, rather than selecting traditional 1:1 care. Those opting for 1:1 care following the GI, demonstrated improvements across all measures, which included level of activation, function and quality of life. The magnitude of these changes however differed from those anticipated by the project team.

When reflecting on the learning from the project, the team recognised the challenges that delivering the GI across 6 localities provided. This decision was driven from co-production with PLBP and staff alike ascribing to 'Closer to Home' service standards. However delivery across 6 sites may have extended the project too fast too soon, putting generalisability above fidelity to the clinical intervention and creating governance challenges.

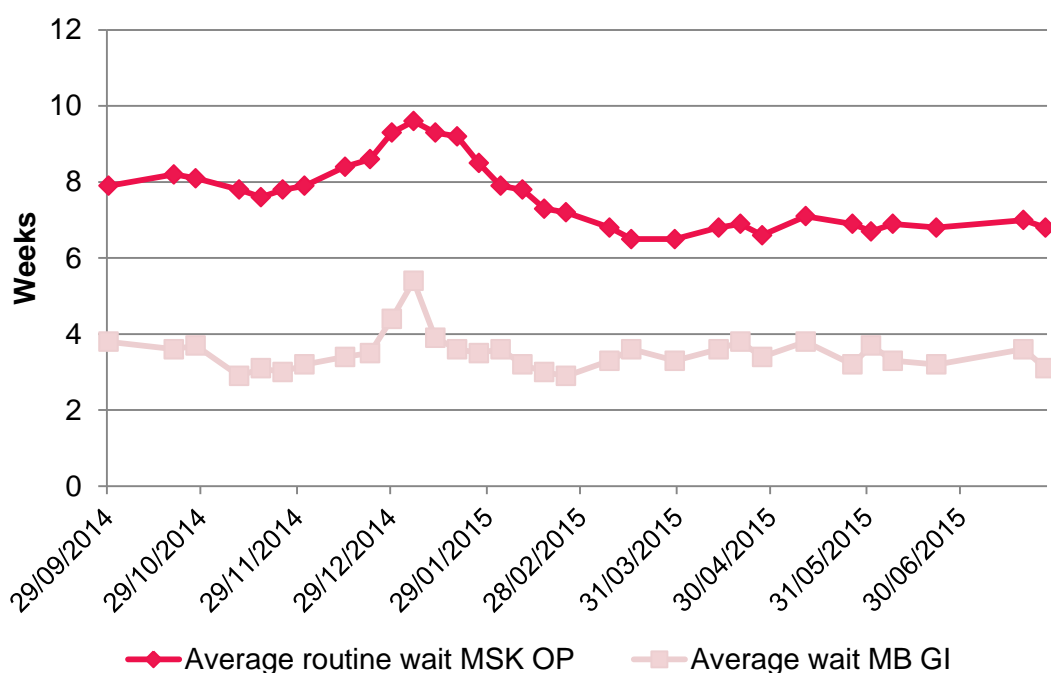
Beyond the SHINE 2014 project, the team have identified opportunities to further develop and enhance the MB model. Through this work it is hoped that this patient centred and prudent model of care will be provided with the opportunity to spread and thrive in the current healthcare environment in order to meet the challenge of supporting and empowering PLBP.

Figure 3 – Manage Backs pathway transformation



What has this collaboration delivered? One of the first outcomes targeted was to deliver a fast-tracked GI, with PLBP attending within 1 month of referral. Figure 4 demonstrates the average wait for a GI throughout the implementation phase.

Figure 4 – Average wait for Manage Backs GI



During the course of the project 85 GI were delivered across 6 sites, with an average of 7.2 PLBP at each session. The GI and subsequent 1:1 pathway activity data is displayed in Table 1.

Table 1 – GI and 1:1 activity during the MB implementation phase

Manage backs pathway component	New patient (NP)	NP Did Not Attend (DNA) rate
GI	611	14.6%
1:1 care	370	6.1%

So having achieved our target of early engagement and delivering the GI to a significant number of PLBP – what were our broader project aims and their outcomes?

1. Provide PLBP with the knowledge and understanding to engage effectively in decisions and self-management strategies;
2. Enhance the physiotherapy teams attitudes and beliefs to support this heightened patient engagement;
3. Reduce currently wasted healthcare resources.

To capture the impact of MB on the first aim self-report measures were collated from PLBP who had physiotherapy treatment either before (traditional model) or during the implementation of MB (GI model). The measures were designed to capture how confident a person feels managing their health (Patient Activation Measure), how they rate their ability to perform functional activities (Patient Specific Functional Scale) and how they rate their health related quality of life (EQ-5D).

The clinical self-report mean outcomes demonstrated improvements in all measures across both models (Table 2). The magnitude of this improvement was greater in the GI model for activation, but was shown to be lower for function and quality of life, when compared to the traditional model. This comparison however is confounded by important differences in the

method of data collection which may have introduced bias and significant differences between the groups. For example, in the traditional group nearly 80% reported the highest attainable level of patient activation at the start of treatment compared to under 32% in the MB Group. This suggests one group endorsed exceptional confidence in self-managing their LBP and may have compromised the changes seen. The level of significant change was determined through comparison with reported levels from the literature.

Table 2 - Average changes and percentages of patients achieving significant change on clinical self-report outcomes

Clinical self-report outcome	Traditional model (baseline measure)			GI model (implementation phase)		
	Sample	Mean change (SD)	% achieving significant change	Sample	Mean change (SD)	% achieving significant change
Quality of Life EQ-5D Index	25	0.16 (0.12)	44%	17	0.02 (0.15)	28%
Quality of Life EQ-5D VAS		8.4 (10.77)			5.76 (15.04)	
Patient Activation PAM	24	0.21 (1.06)	25%	41	0.59 (0.18)	51.2%
Functional Activity PSFS	23	2.95 (2.06)	56.5%	37	2.67 (0.60)	48.7%

A validated measure of patient satisfaction was used to evaluate patients' experience of the service. The results (Table 3) suggested that satisfaction rates were high (Maximum score 5) across both models, though the GI model achieved slightly lower scores with the exception of the booking process.

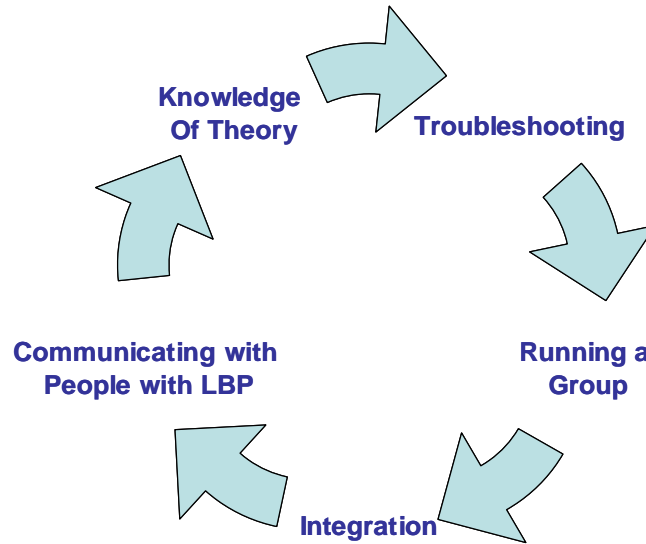
Table 3 – A quantitative measure (MedRisk) of patient experience of the traditional and GI model of care

	Traditional model (baseline measure) (n=26)	GI model (implementation phase) (n=56)
External factors (processes and interaction with department)	4.2	4.3
Internal factors (patient-therapist interaction)	4.8	4.5
Generic average	5.0	4.6
Average total score	4.7	4.5

The second project aim focused on the attitudes and beliefs of the physiotherapists. It was recognised that in order to effectively motivate self-management and decision making during the GI, enhancing physiotherapist beliefs and competence towards a biopsychosocial understanding of LBP and functioning was vital (Darlow, et al 2012). A training and

mentoring programme was developed and delivered to address this need (Figure 5). Eight MB and 25 Outpatient Physiotherapists (OP) completed the HC-Pairs and PABS-PT on three occasions (Pre-training, mid-point and project end) and rated their confidence in GI delivery skills. These measures have been found to be valid and reliable methods of belief measurement (Houben et al, 2005). Fidelity to the model delivery was assured via mentoring and evaluated using a purpose-designed Mentoring Evaluation Questionnaire.

Figure 5 – Components encapsulated in the Manage Backs training and mentoring programme



There was evidence of positive change in beliefs away from the biomedical and toward the behavioural on the PABS-PT (Figures 6 and 7):

Figure 6 – PABS-PT biomedical (Higher scores demonstrate greater biomedical bias)

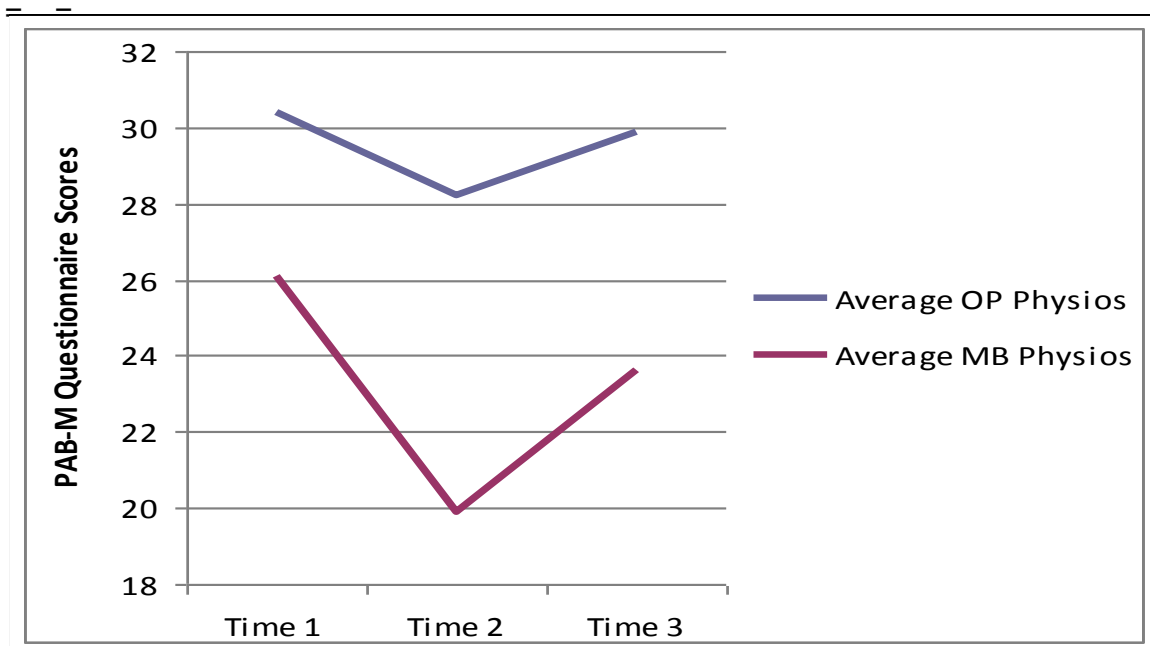
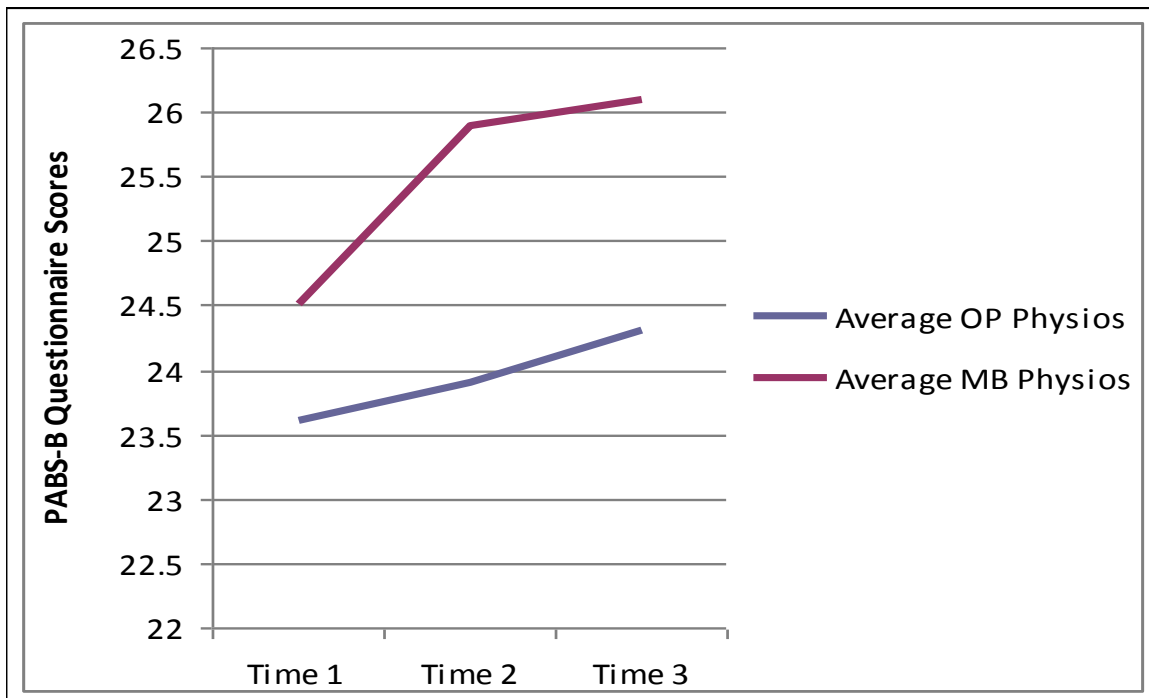
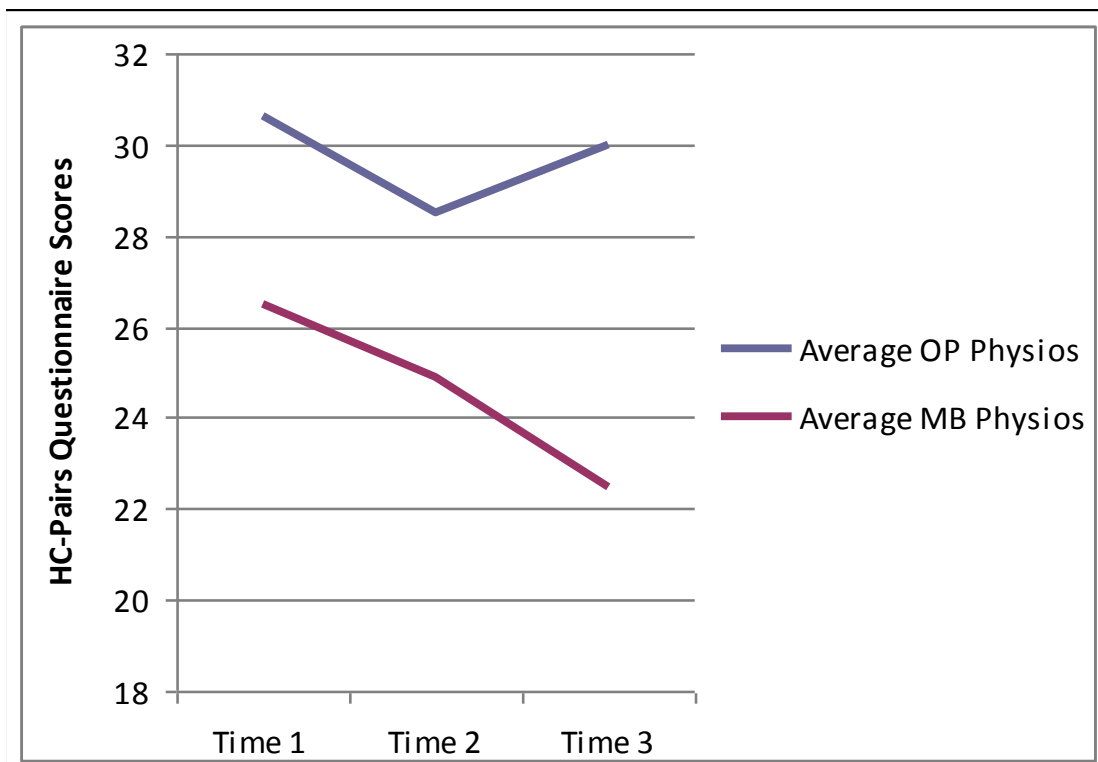


Figure 7 – PABS-PT behavioural (Higher scores demonstrate greater biopsychosocial bias)



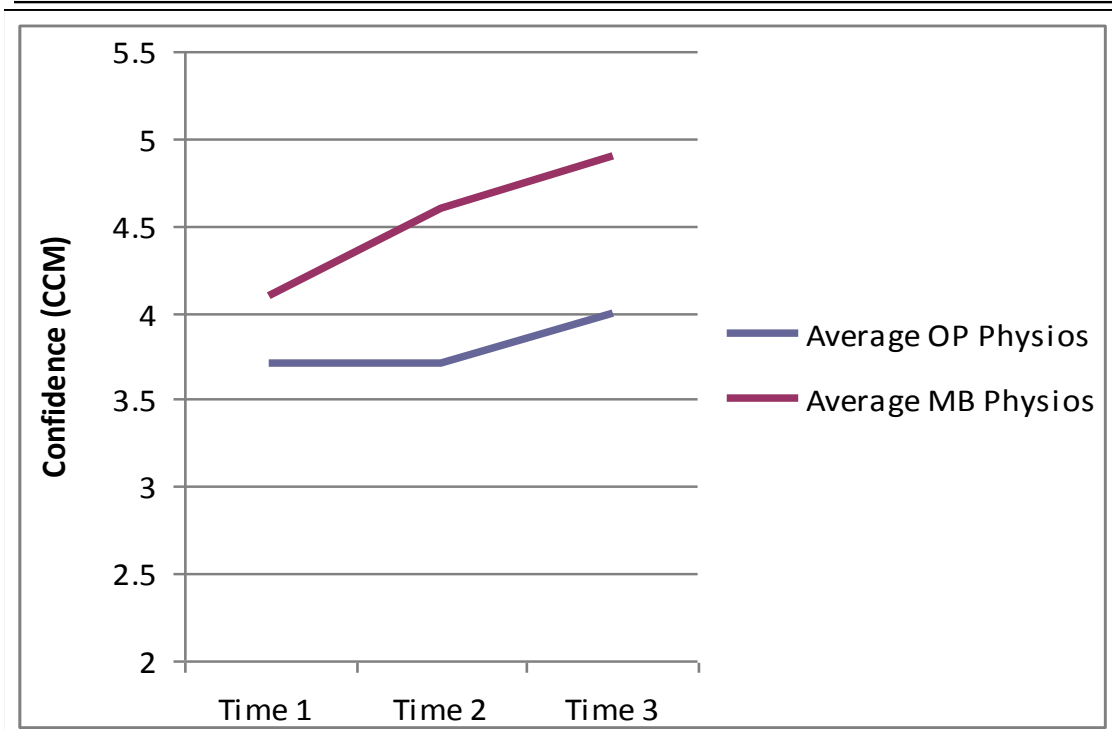
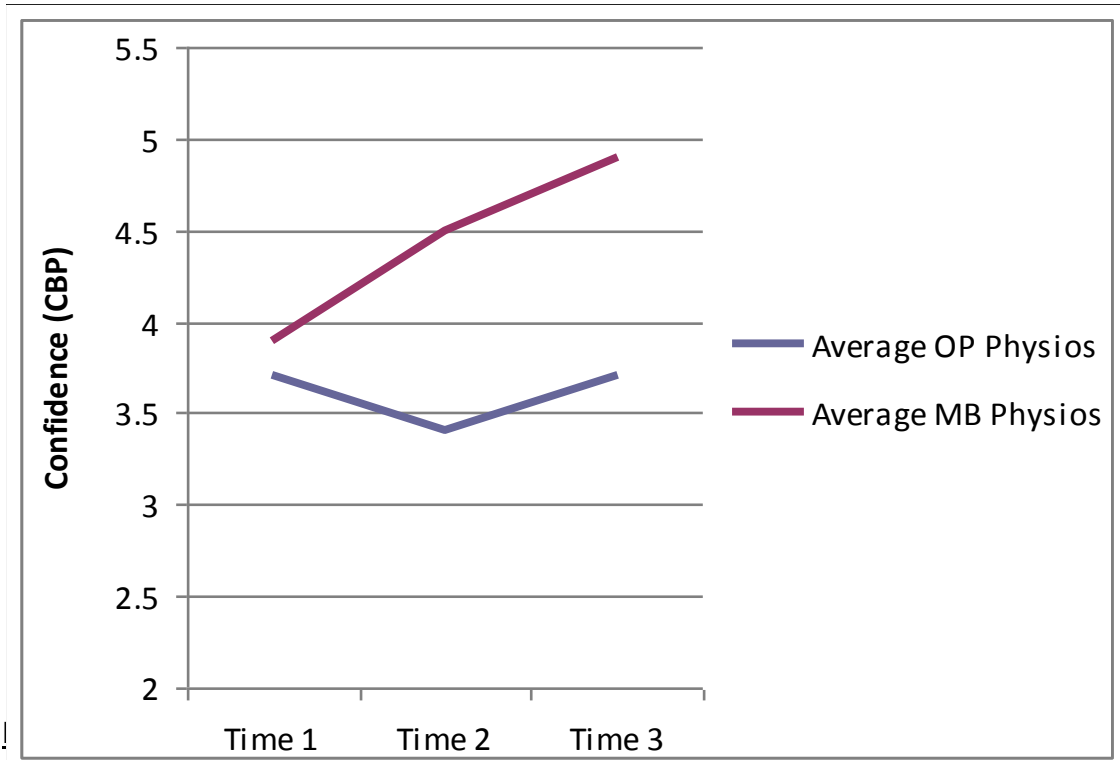
The HC-PAIRS (Figure 8) showed that the OP physiotherapists maintained low functional expectations of PLBP compared with the MB physiotherapists, whose attitudes and beliefs grew more positive about the limits pain places on function.

Figure 8 – Physiotherapists functional expectations of PLBP (Higher scores are consistent with beliefs that pain places more limits on function)



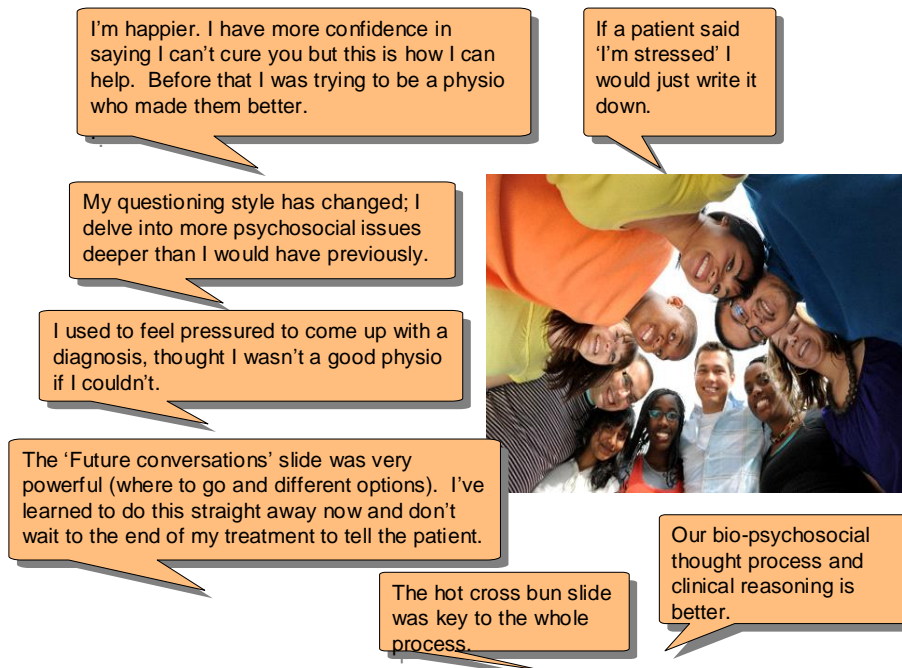
Physiotherapists in the MB group grew in confidence to deliver the GI (CBP: Confidence in back group planning and facilitation), Figure 9, and in the GI as the first contact in the LBP pathway (CCM: Confidence in Clinical Management) (Figure 10).

Figure 9 – Physiotherapists confidence in GI planning and facilitation



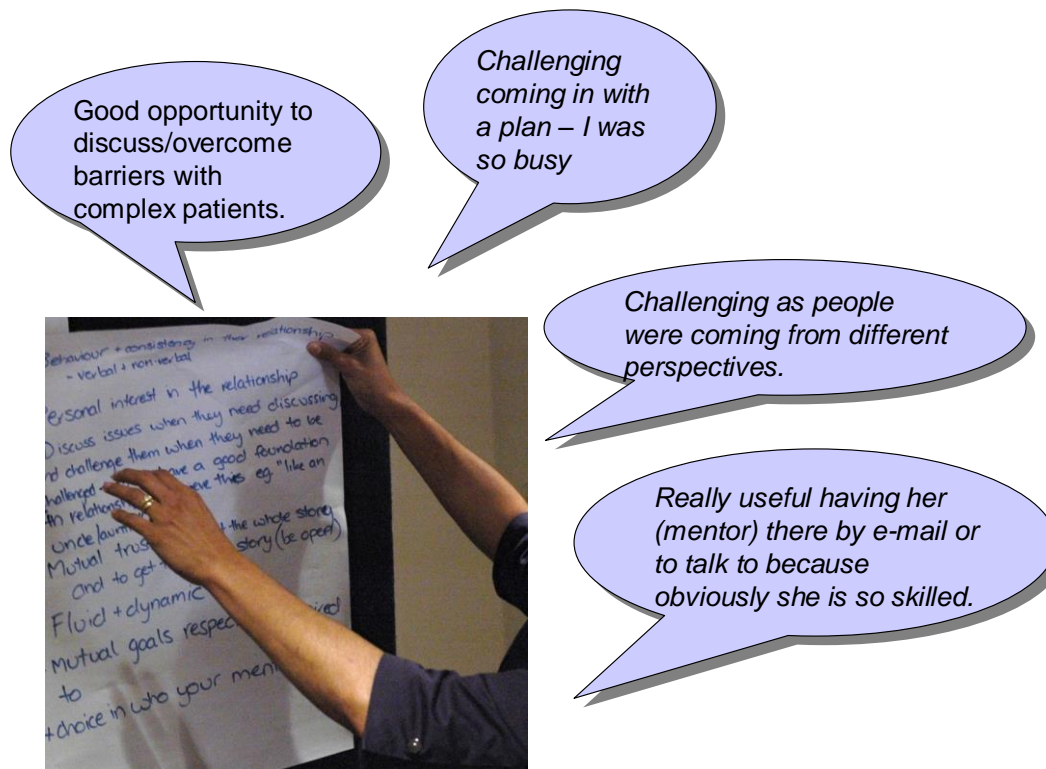
Staff stories, collected by CSI, provided evidence that improved confidence to challenge the beliefs staff themselves held and also those held by PLBP about the meaning of pain, had a positive impact on their practice (Figure 11).

Figure 11 – Quotes from MB staff stories showing belief change and learning



Qualitative (Figure 12) and quantitative feedback (Table 4) showed that the mentoring process supported learning.

Figure 12 – Comments from staff stories (n6) on the learning supported by the mentoring process



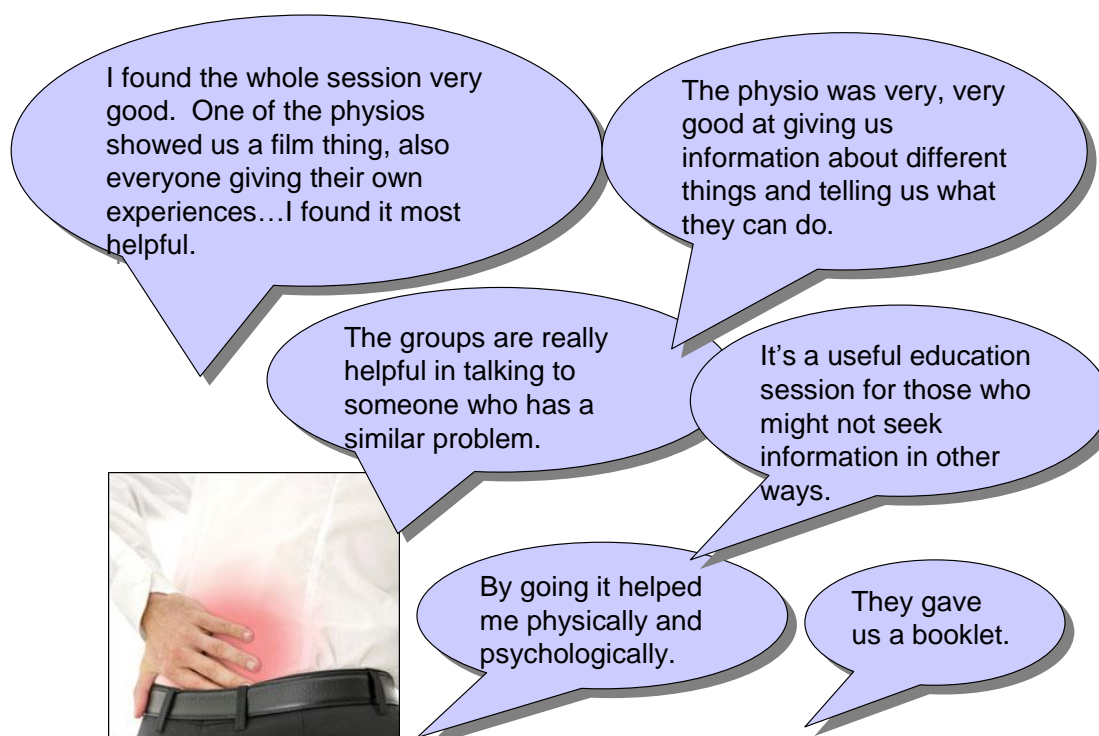
The Mentoring Evaluation Questionnaire captured pre-post changes in applied learning outcomes with practise delivering the GI and reflection through mentoring (Table 4).

Table 4 – Changes in applied learning outcomes in physiotherapists following mentoring

Mentoring Evaluation Questionnaire category	Items per subscale with pre-post rating $\geq +2$
Communicating with patients	47%
Theoretical Knowledge	52%
Integration	56%
Troubleshooting	38%
Running a Group	32%

The CSI team captured patient stories with three PLBP who had attended the GI. Comments (Figure 13) and learning themes (Appendix 2.2) from these stories helped shape the GI.

Figure 13 – Patient story quotes on their experience of attending a GI



The final project aim was to reduce currently wasted healthcare resources. The outcomes here appear unequivocal. The changes in these outcomes between the traditional and the GI model are displayed in Table 5.

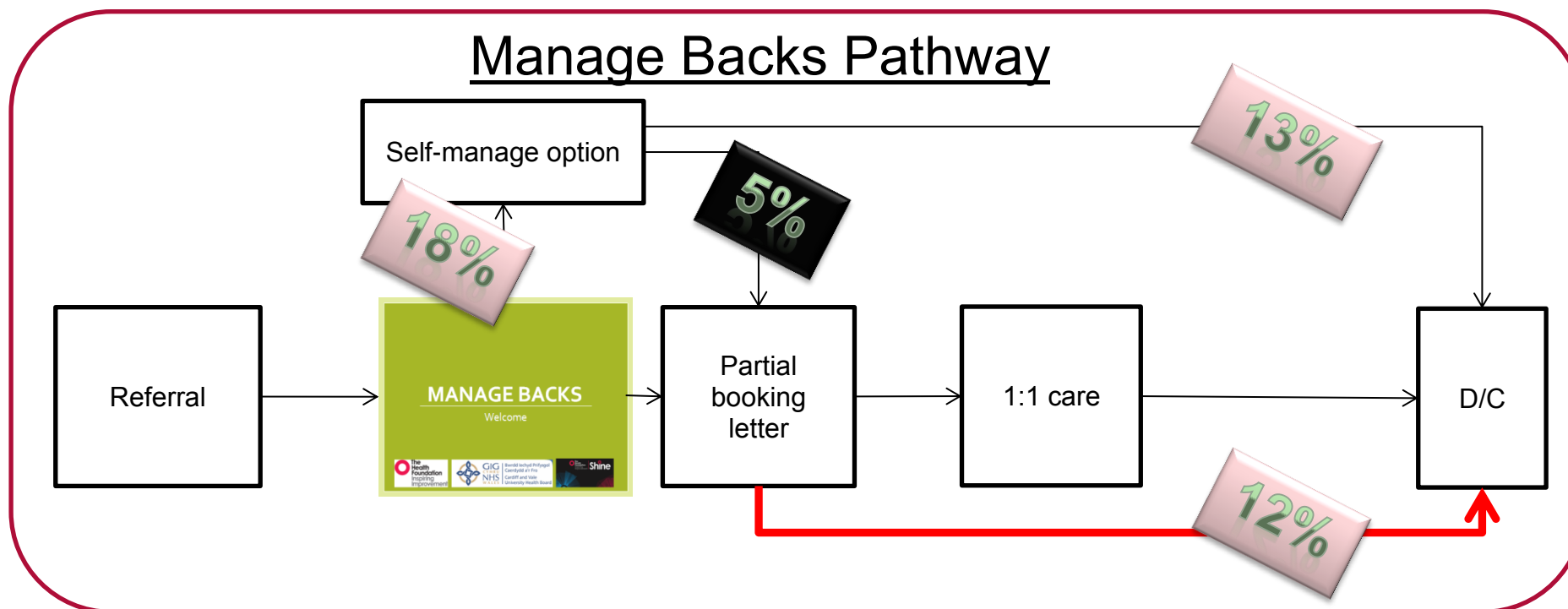
Table 5 – Efficiency of healthcare resource utilisation: comparison between traditional and GI model

Efficiency outcome measure		Traditional model (baseline measure)	GI model (implementation phase)
Pathway carve out	Primary	N/A	13%
	Secondary	N/A	12%
New Patient (NP) 1:1 DNA rate		7.2%	6.1%
NP to Follow-up (FU) ratio: low risk (1*)		1:3	1:1.8
Re-referral: high risk (1*)		18% (1 yr FU)	6.7% (9-12 months FU)

1 Risk level relates to patient categorisation on the STarT Back Screening Tool*

The pathway carve out described in Table 5 is depicted in Figure 14. The primary carve out refers to the PLBP who were discharged having selected to self-manage at the end of the GI. While the secondary carve out describes PLBP who were discharged during the extended decision space afforded by the partial booking process which follows the GI.

Figure 14 – Primary and secondary curve out from the Manage Backs pathway



The cost impact of these reductions in wasted healthcare resources is described further in Part 3.

Part 3: Cost impact

When considering how to demonstrate the financial impact of the Manage Backs (MB) model three key areas were identified. The findings from these areas allow the project team to clearly identify reductions in wasted healthcare resources and then quantify this impact from a cost perspective.

Cost of delivering traditional model of care

The costing work for the traditional model of care, described in detail in the project proposal and mid-point report, was based on 2000 routine PLBP accessing the service from primary care. The clinical delivery cost of this model was calculated to be £174,052.80 per annum.

Cost of delivering the GI model

The clinical delivery of the GI and the provision of support materials cost £9,165.48 per annum. During the implementation phase 85 GI were delivered with 611 new patients attending for support with their LBP. The costs of delivering the GI model were therefore:

- £107.83 per GI
- £15.00 per patient attendance

The average number of patients attending each GI was 7.2. The GI has the potential to support a higher average number of patients, which would deliver a reduction in cost for each patient attendance and GI delivered.

Measures to capture wasted healthcare resources

One of the MB aims was to attempt to reduce currently wasted healthcare resources. The project team was able to identify areas where it anticipated that the GI might demonstrate a lower utilisation of healthcare resources than the traditional model. The indices identified were:

- Pathway carve out
- New patient 1:1 DNA rate
- New patient to follow-up ratio for patients categorised low risk
- Re-referral rate for the high risk patient group

The findings for this project aim were unambiguous, with each of the indices demonstrating a reduction in wasted healthcare resources when compared to the traditional model (Table 5, Part 2). The impact of these potential savings on the delivery costs of both the GI and traditional models has been calculated. These savings, once the cost of delivering the GI has been accounted for, are displayed in Table 6.

Table 6 – Cost impact of reductions in wasted healthcare resources between the GI and traditional model

Reduction in wasted healthcare resources		Cost savings from reduced wasted healthcare resources	
		GI model (611 patients) Delivery cost £9,165	Traditional model (2000 patients) Delivery cost £174,052
Pathway carve out	13 % primary carve out	£6,100.16	£19,967.80
	12% secondary carve out	£5,630.92	£18,431.81
New Patient (NP) 1:1 DNA rate reduced by 1.11%		£172.94	£561.00
NP to Follow-up (FU) ratio: low risk reduced from 1:3 to 1:1.8		£1,154.79	£3,996.00
Re-referral: high risk reduced by 11.34%		£1,590.15	£5,205.06
Total model savings		£14,648.96	£48,161.67

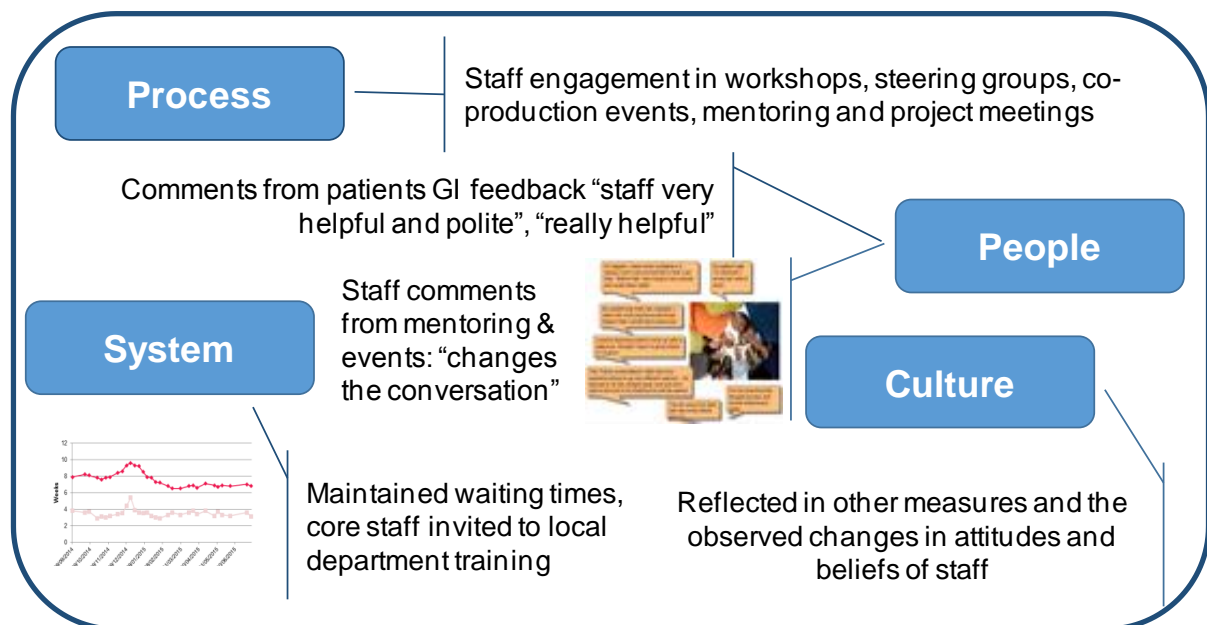
If the GI model were transferable, assuming 2000 PLBP per annum received MB, the potential saving would be £48,161.67. This represents a reduction in pathway cost of 28%.

Reference does need to be made to the 11.34% reduction in re-referral of high risk patients. The traditional model cohort had been discharged for 1 year. However the 1 year duration of the implementation period and subsequent report deadline necessitated the use of a cohort for the GI model analysis who had been discharged between 9 and 12 months. Therefore this 11.34% reduction in re-referral will be impacted by any further re-referrals over the next 3 months. However, even in the unlikely scenario that there was not a cost saving from a re-referral perspective, the overall reduction in traditional pathway cost would still be significant at 25%.

Clinicians

This model of care presented clear challenges to physiotherapists accustomed to delivering a traditional pathway to PLBP. The MB team therefore developed a bespoke training and mentoring programme, to foster development and provide support for the MB clinicians. The impact of this programme on the attitudes and beliefs of these physiotherapists is clearly demonstrated in Figures 6-10 (Part 2). Healthcare research utilisation and experience gained from delivering this programme, allowed the development of a competency list (Appendix 2.3). These learning outcomes can be used to further operationalise future training packages to support this novel clinical model of care. Physiotherapists' acceptance of the MB model was apparent from a number of sources (Figure 16) and created a 'ripple effect' (Appendix 2.4). A training session to raise awareness of MB, GI content, its significance for staff beliefs and future conversations was provided to those physiotherapists not delivering the GI. Although well received, it seems to have had a limited impact on their beliefs or confidence (Figures 6-10, Part 2) consistent with Overmeer et al (2011).

Figure 16 – Evidence of clinician acceptance of the MB model from varying sources



Services – Physiotherapy & Psychology

In championing and hosting the GI, services demonstrated acceptance and understanding of how this model of care was prudent, supported PLBP and was aligned with current healthcare policy drivers. These drivers included: patient centred care, co-production, shared decision making, self-management skills and delivering the minimum appropriate clinical intervention. The GI, developed through co-production, has fostered patient choice and self-management skills and clearly represented a minimum clinical intervention. This is evidenced through a potential reduction in wasted healthcare resources leading to reduced pathway costs of up to 28% (Table 6, Part 3).

Further questions

The project findings highlighted above appear to describe engagement with and acceptance of the GI by PLBP, clinicians and services. These findings have also provided evidence to justify claims that the following project aims have been achieved:

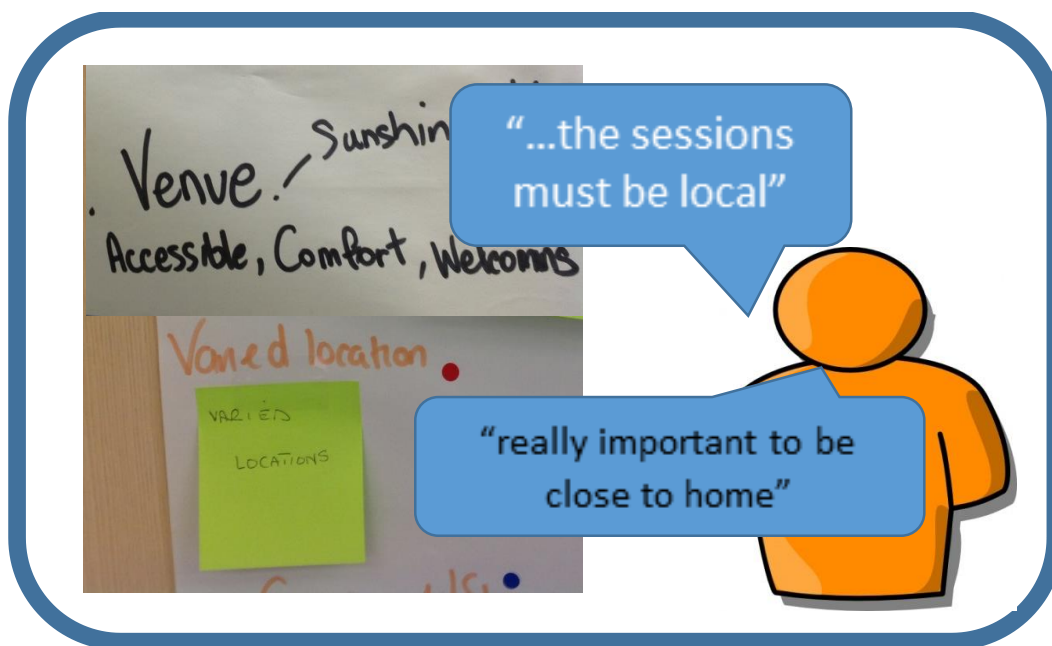
- Enhance the physiotherapy team's attitudes and beliefs to support this heightened patient engagement
- Reduce currently wasted healthcare resources

The clinical self-reported outcomes differed from those anticipated by the project team. These outcomes (Table 2, Part 2), although showing improvements across all measures, left questions as to the strength of the GI as a clinical intervention. These questions therefore challenged the project's aim to:

- Provide PLBP with the knowledge and understanding to engage effectively in decisions and self-management strategies

The team reflected that this was possibly because the model was delivered across 6 locality sites. This decision was driven by the team's wish to remain true to a co-production methodology, where both patients and staff alike were ascribing to 'Closer to Home' service standards (Figure 17). They also wanted this project to impact on the whole service and not just a single locality. However, on reflection this expansion across 6 sites, whilst a considerable strength, may have extended the project too fast too soon, putting generalisability above fidelity to the clinical intervention and creating governance challenges.

Figure 17 – The value placed on 'Closer to Home' service standards from co-production events



It is possible to track the impact of this decision at a clinical, operational and evaluative level.

Clinical

Demographically Cardiff, like most large cities, has a diverse population with differing expectations and requirements from healthcare services. The challenges this provided for the early, clinically immature, GI model required significant resources from the MB team in order to identify and then evolve the model in response. Had the model been developed in a

single locality, it is likely that a clinically robust and transferable GI would have been achieved earlier in the implementation phase and with less resource investment.

Extended delivery also impacted on wider service training, through increasing the number of staff requiring training. The training resources allocated to OP physiotherapists were lower than those GI staff being actively mentored. The limited impact of this on the changes in wider staff's attitudes and beliefs can be seen in Figures 6-10 (Part 2). Perhaps the non-GI clinicians were inadequately prepared to have 'future conversations' with patients when they entered 1:1 care, and if so this may have contributed to the magnitude of the clinical outcomes demonstrated?

Operational

Delivering on additional sites potentially exacerbated the variation in locality demand, which produced fluctuations in the number of patients attending GI. Feedback from both PLBP and clinicians suggested lower numbers within the GI had the potential to lessen its impact, due to changes in group dynamics. Delivering on fewer sites would have allowed closer operational controls to have been put in place to ensure optimum numbers of patients attending GI.

Evaluative

Evolution of the GI clinical model required adaption of the evaluation plan plus impacted on timescales for data collection. There were challenges in capturing data across the 6 locality sites and variation in collection, postally or at point of discharge. Collection modality may also have influenced the data quality of the clinical self-reported outcomes.

Mixed picture

The GI model of care has been accepted by all stakeholders. It fits closely with current healthcare drivers. It saved wasted healthcare resources. It supported learning and changed physiotherapists' attitudes and beliefs. It was effective and clinically safe. Some questions remain as to the magnitude of its strength as a clinical model with concerns arising about quality of the clinical outcome data and differences across groups.

Part 5: Plans for sustainability and spread

Delivery of the GI model was authorised by the Health Board for the duration of the implementation phase. Beyond that phase the future delivery plan requires sign off from the Heads of Service in both Psychology and Physiotherapy. This plan will identify the clinical and resource impacts demonstrated during the SHINE 2014 project. Additionally governance, staff development and finance models will require finalisation. It is anticipated this delivery plan will be ready for submission in October 2015.

In moving the model forward, as part of its establishment within the service, there are two areas that the leadership team consider of vital importance. The first of these relates to exploring further its strength as a clinical model. Immediately this would be achieved by enhancing clinical, operational and evaluative aspects identified in Part 4, and then capturing the impact these changes produced on the model's outcome measures. There is also the drive within the team to look at translating the service improvement level of evidence, developed during SHINE 2014, to that of a methodologically robust feasibility study. In preparation for this the team has attended the Research Design & Conduct Service Workshop during September 2015. This provided the opportunity to horizon scan, while also gaining practical advice to enhance the likelihood of success during the applications process.

The second area identified was to operationalise and implement the clinical competencies list. This list was developed from the evidence base and concepts which arose during the MB mentoring process (Appendix 2.3) and was used to define the learning outcomes and skills necessary to clinical performance in delivering the GI. Translating this competency list into an operational framework would support succession planning within Cardiff & Vale UHB. Additionally the value this would add in supporting the spread and embedding of the GI within other services would be significant. Having held discussions with the Health Foundation, their Spreading Improvement Programme has been identified as a potential platform to support the progress of this plan over the next 12 months. The MB team are keen to submit an application for this programme in October 2015.

Enhancing the GI level of evidence and the operationalising of the competencies training list would position the MB model strongly to capitalise on available spread opportunities. These spread opportunities appear to primarily encompass the three categories identified in Figure 18.

Figure 18 – Identified categories providing opportunities to spread the GI model

Broaden inclusivity	Pathway shift	Spread geographically
<ul style="list-style-type: none">•GI delivery to support other physical conditions (e.g. OA knee)•Explore generic GI targeted at supporting all patients with MSK needs referred to physiotherapy•Discussions ongoing within the physiotherapy service	<ul style="list-style-type: none">•Transfer the GI model location from its primary care setting:•To community care as self-referral•To secondary care to support patient engagement with interventional decision making•Contacts made with both primary and secondary care	<ul style="list-style-type: none">•Explore opportunities to spread GI beyond the Health Board•Interested parties include; Berkshire NHS Foundation, South West Commissioning Support, Cwm Taf NHS University Health Board, Abertawe Bro Morgannwg University Health Board

The spread opportunities and the underpinning contacts that have been developed and identified in Figure 18 have been the product of the significant investment in dissemination to raise the project's profile. Examples of the output of this profile work is included Table 8.

Table 8 – Spread opportunities for Manage Backs during the SHINE 2014 programme

Activity date	Type of activity	Setting
April 2014	Media coverage	Frontline (Appendix 2.5)
June 2014	Platform presentation	Cardiff & Vale UHB HCPC conference
June 2014	Presentation	Quality, Safety & Improvement Faculty
September 2014	Presentation	Clinical Psychology and Counselling Annual Service Wide Meeting
September 2014	Media coverage	Frontline (Appendix 2.5)
February 2015	Presentation	Annual Department of Clinical Psychology Postgraduate Workshop
June 2015	Poster presentation	Cardiff & Vale UHB Research Conference (Appendix 2.6)
June 2015	Poster presentation	Cardiff & Vale UHB HCPC conference (Appendix 2.6)
September 2015	Presentation	Quality, Safety & Improvement Faculty

Beyond the SHINE 2014 project the team are keen to continue to develop the MB GI model and harness further opportunities to share our learning. Through this work it is hoped that this patient centred and prudent model of care will be provided with the opportunity to thrive in the current healthcare environment by ensuring successful spread both within and beyond the Health Board.

Appendix 2: Resources from the project

Please attach any leaflets, posters, presentations, media coverage, blogs etc you feel would be beneficial to share with others

Appendix 2.1 – Learning themes from patient stories

Learning from themes from interviews and co-production shaped the GI from mid-way:

- **Invitation letter clarity was improved:**

“I wasn’t entirely sure at first as I thought (GI) was this replacing an individual session? I told my husband I would give it a go. I hoped that there was going to be some individual attention as everybody’s back problem is different. I was uncertain at first- unsure. The letter is not clear although it is made very clear at the session that you can have a 1:1 if you wish”. P1

- **GI process incorporated more time for participant interaction:**

“It was helpful when we split into 2 groups – (bit like an AA session!) –it was good to share ideas and experiences with each other of things that have helped. It felt good to meet others with similar problems- I met someone of my own age.” P2

- **GI content included a case study to enhance person-centred interaction and group size was optimised where possible:**

“I definitely liked the keeping active message – you shouldn’t let your back pain stop you doing different things to keep yourself active, and the message about pain not necessarily being bad pain and you are doing anything necessarily wrong but pushing through will better for you on the other side” P2

“I wanted more content on what you can or should be doing. But then I know it’s hard if you are doing big groups it’s hard to find exercises that suit everyone. I think you could double the numbers on the course.” P2

- **Decision making messages were articulated clearly:**

It is made very clear at the session that you can have a 1:1 if you wish”. P1

“It did still put it back on me to be responsible for recovery and doing what I could to help the pain, to stop the pain,” P1

The Ripple Effect:

For Physiotherapy: Potential impact for whole LBP care pathway

- P3- The wider effect on the physio team has been immense-the ripple effect. It is changing people’s perspectives of LBP. It could be massive and a great tool to disseminate to band 5’s and 6’s. I really believe in how much you can influence someone’s experience by using the bio-psycho –social effect and by being patient –centered”*
- P4- “Not over-treating- with the low risk patient I am more likely to advise and discharge much quicker. I’m pushing self-management much quicker. In the group the “Future conversations” slide was very powerful (where to go and different options) I’ve learned to do this straightaway now and don't wait until the end of my treatment to tell the patient”*
- P5- “The SHINE group department has seen a massive change in patients coming back and discharging them sooner. Already on initial out-patient appointment the patient is on board- it’s normalised the situation and promotes self-management. I can be more focused on meaningful living and goals with patients rather than pain. Patients arrive often very upset and distressed at beginning of the group and they have been happier at the end and have said they can manage themselves. These would have been patients who previously would have come back time and time again. I used to think I had to cure patient - I know now that’s impossible if patients mind isn't in the right place- if you don't recognise the context that person lives in. Patients are more aware when they come to a 1:1 they are not expecting acupuncture etc and realise they have to learn to live with this.... Good knowing about readiness to change.*
- P6-“There is huge power in patients learning from each other. In physio I had not really thought about it in that context. We have always run groups for exercise but never for discussion or information groups incorporating patients learning from each other”*

For interactions with and between people with LBP:

- P3-“Quick access to the service and reassurance from other patients. Group intervention patients are a bit nervous at first but by the end they less nervous and take comfort from talking to others I never thought it could be so powerful. It’s about having someone walk in their shoes- to be validated by another patient”.*
- P4- “Early advice. The initial conversation is much different after the patient has been to manage backs. Starting thought process of self-management already so when they come and see us they are already starting to make changes and doing things differently”*
- P6- “In whole process trying to get message early on - how successful powerful they can be in management of this problem”*
- P1- “Feel like this gives them a choice. Empowers patient from the start, they have the power to make those decisions. Signposting to different elements of the service”*

Appendix 2.3 – MB coverage in the media

The Manage Backs project has received coverage in by the Chartered Society of Physiotherapy (CSP) of the project in both print (Frontline) and internet mediums. Details are of the coverage are included below:

April 2014: <http://www.csp.org.uk/news/2014/04/29/welsh-health-board-pilot-group-treatment-low-back-pain>

September 2014: Comment and project profile provided as part of an article titled 'Managing Pain'. The article below was produced in both print (Frontline) and internet mediums.



34 Pain management

THE WHOLE PACKAGE IS ABOUT HOW SOMEONE MIGHT PRESENT WHEN THEY'RE IN PAIN'
Ian Taylor

complete competence framework is still some way off. A lot of physios are saying this is fine but we want you to define what competence is. Really, we're at the stage before that. This is the underpinning piece of work from which we will then develop the competence framework.

That said, the first stage is ambitious in its scope in that it tries to capture the range of work undertaken by physios who manage pain, in a wide variety of settings. That work includes

- requesting investigations
- prescribing
- administering injections
- planning, monitoring, modifying and carrying out treatments
- supporting patients in coming to terms with their pain
- conducting complex assessments, including questions about deliberate self-harm.

The PPA document draws on the CSP's physiotherapy framework, which defines the behaviours, skills and knowledge required for contemporary physiotherapy practice. Mo Wilson says: 'That really broke down the core components of physiotherapy and so we said, okay, what's different about pain-management physio and how do we capture that using a framework? We've taken a very complex area and tried to distil it down to get at what's at the heart of it'

The PPA framework describes the behaviours, skills and knowledge for physios at four different levels: entry-level graduate, experienced graduate, advanced and expert. It outlines the knowledge and understanding expected for each level in a number of different domains, such as understanding of acute and chronic pain and its management, communication and promoting teamwork.

Pain management
Ian Taylor, head of physiotherapy for the adult learning disability service at Kent Community Health NHS trust, embodies expertise in each of those domains. He also illustrates the scope of pain-management work undertaken by physios.

Mr Taylor has a long-standing interest in undiagnosed pain in people with learning disabilities, which, because of communication issues, can often manifest itself in a person's behaviour. In partnership with a consultant nurse in chronic pain, he devised a training package for carers to help them identify when a client is in pain.

"The problem we've got is that clients with learning disabilities are communicating they're in pain but what we, as carers, are not doing is picking up those clues," says Mr Taylor. He cites as an example an older woman who, when carers tried to help get her up in the morning, used to hit out. "People said she had challenging behaviour. What she actually had was quite severely arthritic hips but nobody had picked it up. She couldn't say, "My hips are sore, don't move me," so she was striking out instead."

Thinking differently
The training is designed to make carers think differently. "The whole package is basically about how someone might present when they're in pain and different strategies to then manage that pain," says Mr Taylor. Called 'I hurt, help me', the package helps build a pain profile for the individual. It is drawing interest from across the UK and he hopes it will be rolled out beyond Kent.

On the other side of the country, George Oliver and Graeme Paul Taylor also exemplify physios' innovative approach to pain management – albeit in a markedly different way from elsewhere.

The physiotherapy service at Cardiff and Vale University health board has won funding from the Healthcare Foundation's Shine programme to trial a group approach to patients' low back pain.

Mr Oliver, the health board's clinical lead physio, says the idea is to 'change the nature of the conversation' and to make sure psychological and social aspects of patients' back-pain experiences are fully and not within their management.

Developed in partnership with the psychology service, the idea is to switch patients' first point of contact from a one-to-one setting to a fast-tracked group intervention. Patients are invited to attend the group. They are not obliged to do so but those who do can then choose between individual physiotherapy or self-management. A stratification tool will be used to ensure that those who opt for the former see the most appropriate person for their needs. Mr Oliver says: "We looked to try and change the front end of that traditional assessment framework, and how the patient is then managed and supported within the physiotherapy service."

Mr Paul Taylor, physio lead for the project, says it aims to empower patients and help them reframe their problem. "We think it would be helpful to move people away from a very biomedical, physical way of thinking about their back pain and ensure that their conversations with physios include all those biopsychosocial elements."

All key stakeholders, including service users, were consulted about the new approach and the physios involved have been given extensive further training in back-pain management. "The new part is working in a group intervention," says Mr Paul Taylor. "That's the bit that's creating excitement – as well as a bit of anticipation. But I think it will go really well."

A mid-term review will assess progress at six sites across the health board, with a final report in October next year. //

7 October 2014

Low back pain care pathway transformation: Self-management groups in primary care.

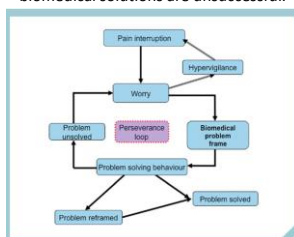


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Low Back Pain is one of the most common musculoskeletal complaints worldwide, with lifetime prevalence rates as high as 84%. Recent Welsh reports (Bradley, Wilson, 2014) advocate developing self management skills of service users experiencing persistent pain.

Ecclestone (2011) suggests: people with persistent pain actively problem solve within a biomedical problem frame. This does not address the worries, fears and avoidance of activity that impact on disability

Figure: Perseverance loop caused if biomedical solutions are unsuccessful.



Manage Backs is a Health Foundation funded project that re-designed the first point of therapeutic contact for service users (SU) referred to physiotherapy with low back pain to a group intervention (GI) which addresses unhelpful beliefs about pain and promotes activation.



Co-production

A transformative co-production model was adopted to inform 2 events that firstly designed then evaluated GI implementation.

PDSA cycles were utilised from Quality Improvement Methodology (1000 Lives, Improvement, 2014)

- SU Involvement
- Action Research
- Co-produced GI
- Novel Intervention



The project team felt that the novel GI needed to be developed with local service users and stakeholders to support a culture of supporting people to adopt self management.

The project was led as a collaboration of Physiotherapy and Clinical Psychology with the support of the Continuous Service Improvement Department. Stake holders who participated included: Physiotherapy; Clinical Psychology; Occupational Therapy; Nursing; Consultants in Clinical Psychology, Public Health, Spinal Orthopaedics, Pain; Expert Patient Programme; Support Staff.

Two events were planned, the first to inform the design, key messages and delivery of the GI. This workshop utilised consensus methods to recognise priorities that could inform the development of the GI and training of 12 key physiotherapists who delivered the 'Manage Backs' intervention that was developed.

The second event was a reflective evaluation of the first implementation. It included SU who had both been involved in the development, SU who had experienced Manage Backs and stakeholders.

The evaluation included data of service use, anonymised feedback questionnaires and 3 patient stories from SU

GI Design

The events were developed to address 3 questions:

- What is self-management?
- How would people want self-management introduced into the conversation?
- What would the perfect group intervention look like?

Do the event Emerging themes were coded. Content emerging from the self-management question are illustrated through a word chart and emergent themes included:

taking control, knowledge and skills, understanding and processes.



The themes that emerged from the small groups (developed during the event with on table facilitators) with the 'how' question were prioritised by the participants. This was coded so that service users (as a group) priorities could be identified and then used to inform the development of the group intervention. Key messages were identified:



Priorities in its delivery were:

- to be local,
- include facilitated discussion and interaction between SU with lived experience of back pain

Reflective Event

Over 200 SU have attended GIs across 6 different locality sites with over 83% reporting them as useful or very useful. There have been no reported clinical incidents. Manage Backs has been found to be acceptable first points of contact for both SU and staff with 12% of SU opting to self-manage after the group.

The evaluation confirmed:

- the importance of key messages,
- value of SU interactions and peer support,
- physiotherapists reported that SU's who had attended the GI were more goal focussed, confident and more likely to have initiated activity prior to an individual (1:1) appointment



Recommendations for improvement were also identified. These included appointment letters and further development of peer to peer support within the sessions and changes to written materials.



Acknowledgements:

A special thank you to the Continuous Service Improvement team from Cardiff and Vale University Health Board and to the 12 physiotherapists who delivered the group interventions.

Conclusions:

A co-productive methodology informed the development of a novel Group Intervention that was both acceptable and useful to service users. Physiotherapists and wider stakeholders confirmed the value of the GI. The value of the key psycho-education messages and the necessity to include self-management strategies was evidenced

References

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