Podiatry Transforming Vascular Services in Hywel Dda UHB

Katie Evans-Bundy
Diabetes & Vascular Podiatry Service Lead, Hywel Dda University Health Board
katie.evans-bundy@wales.nhs.uk

Background

In April 2024 there was a 24 month wait for both urgent and routine referrals, 1 month for 10-day referrals for Hywel Dda UHB patients to be seen in a Vascular outpatient clinics.

Waiting list exceeded 650 patients waiting over 2 years. Many of these patients could be seen by Specialist Podiatrists for assessment and timely referral to Vascular Surgery if required.

Due to the nature of vascular conditions, especially peripheral arterial disease (PAD) patients were likely to deteriorate during the wait for an appointment. Patients were seen too late and subsequently resulted in problems.

As Podiatrists we triage, assess, diagnose & instigate lifestyle changes for patients with PAD.

Our aim was to reduce vascular surgery outpatient waiting list for Hywel Dda patients. To create capacity for urgent referrals to be seen sooner and appropriately. In turn reduce amputation rates.

Method

Podiatry validated the Vascular waiting list alongside a Vascular surgeon. Assessing suitability of patients to Podiatry assessment.

145 referrals were suitable to be redirected to Podiatry.

106 patients seen in Podiatry Vascular clinics across the 3 counties and provided in depth vascular assessment along with lifestyle advice.

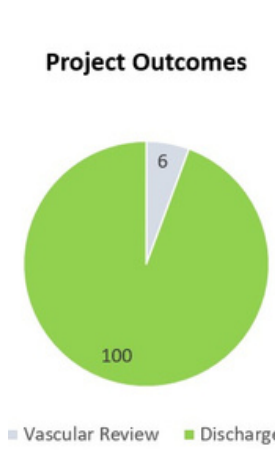
39 patients were removed as patients' symptoms resolved, seen privately or moved out of area.

Safe care was provided by seeing patients in timely manner. Patients were seen across Pembrokeshire & Carmarthenshire to ensure equity across the health board, including as a house call.

Re sults

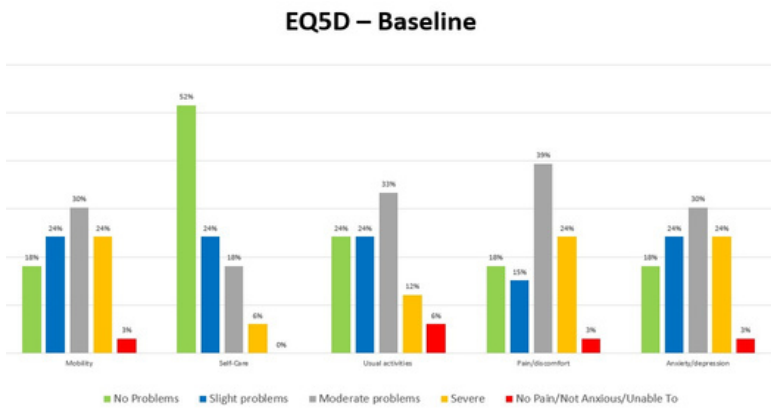
106 patients were seen between December 2023 & end of March 2024.
Staggering 100 patients (94%) were discharged from vascular surgery waiting list.
Out of the 100, 25 patients were kept within Vascular Podiatry for follow up post lifestyle education/advice. 75 were discharged completely due to no/low risk. 6 patients required vascular surgery input, 2 of which had critical limb ischaemia which were expedited & seen by vascular surgery within 2 weeks.

PROM & PREM data were collected via the DrDoctor platform, proving effective patient centred care.



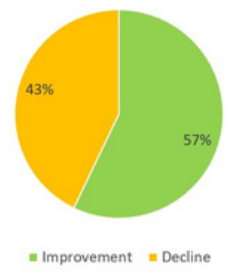
Patient Reported Outcome Measures (PROMs)

PROM was sent to patient pre appt and 2 months post appt using the EQ5D questionnaires. Pre appointment 39% of patients reported moderate issues with pain and discomfort with their usual activities. On completion of PROM after 2 months 57% of patients noted an improvement.



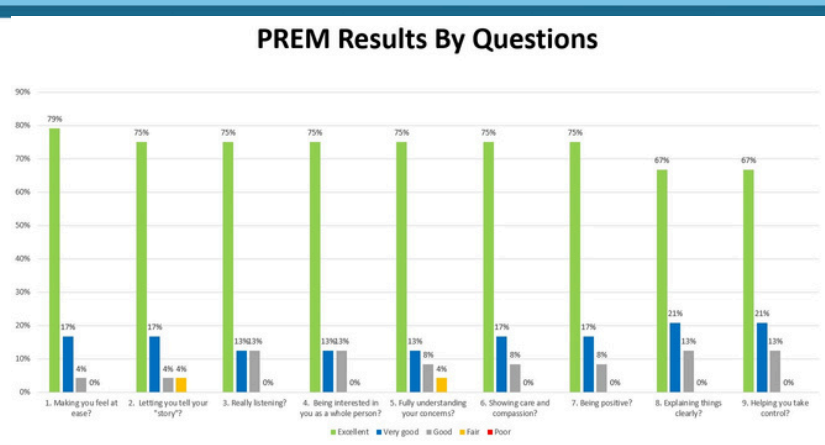
Overall Improvement

- Where patients had completed two PROM forms (baseline and 2 month), the majority of them improved)



Patient reported Experience Measures (PREMs)

Patient reported experience measure (PREM)
PREM data were collected with overwhelmingly excellent response from their experience



Conclusion

As a result of this project, we have appointed a Clinical Advanced Podiatrist (Vascular). This will allow us to,

- Provide more timely care.
- Avoid preventable harm.
- Improve patient outcomes.
- Reduce the cost of achieving those outcomes.

By Podiatrist working at the top of their licence they provide higher value enabling Vascular Surgeons to see patients only they can see. Thus, improving the waiting list for urgent patients to be seen in a timely manner.
Our aim would be to promote and educate primary care on the referral pathway. This will ensure patients are seen by the right healthcare professional at the right time.

Wales Type 2 Diabetes Remission Service

Catherine Washbrook-Davies, MSc, BSc (Hons) RD
All Wales Nutrition & Dietetic lead for Diabetes, CVUHB & NHS Executive
Email: Catherine.Washbrook@wales.nhs.uk

Abstract

Type 2 diabetes (T2D) is a growing health issue globally, which, until recently, was considered to be both chronic and progressive. Although having lifestyle and dietary changes as core components, treatments have focused on optimizing glycaemic control using pharmaceutical agents.

T2D remission should be considered as a treatment goal for people living with T2D, especially for those within 6 years from being diagnosed. Programmes supporting people toward achieving remission need to be structured and offer continued, regular support, including the involvement of dietitians[1].

There are many health benefits of weight loss, even if remission does not occur. It reduces the risk of developing other conditions such as heart disease and certain cancers and can lead to reducing or stopping blood glucose lowering medications, therefore reducing medication costs.

Following the publication of the DiRECT[2] study results, work commenced by Dietetics departments within four university health boards in January 2020 to implement a Wales pilot to test the real-world implementation of delivering a Total Diet Replacement (TDR) based intervention to aid people with T2D to achieve remission through weight loss. 101 patients were deemed eligible, of which 44 completed the 12-month intervention. For patients with two HbA1c results available at 12 months,

Aim

There is a strong relationship between weight gain in adult life and T2D. Lim et al (2011)[3] investigated the twin cycle hypothesis which theorised that excess fat within the liver and pancreas are a causation of T2D. The DiRECT[1] study found that by following an intensive weight management programme which utilized a low energy formula diet 46% of participants put their diabetes into remission.

Following the publication of the DiRECT study results, work commenced in January 2020 to implement a Wales pilot for approx. 90 patients to test the real-world implementation of delivering a Total Diet Replacement (TDR) low energy diet-based intervention to aid people with T2D to achieve remission through weight loss. The work was enabled through investment by the All Wales Diabetes Implementation Group (AWDIG), now National Strategic Diabetes network. The inclusion criteria mirrors

Methods and Materials

Dietetics departments within four university health boards (Cardiff & Vale UHB, Betsi Cadwaladr UHB, Hywell Dda UHB & Aneurin Bevan UHB) agreed to deliver the service. The patients were identified through various routes either direct referral from primary care, self-referral or following attendance at a dietetic intervention. A total of **101 participants** met the inclusion criteria, were screened and deemed eligible for the intervention (refer to table 1 for breakdown per UHB) .

Patients who met the eligibility criteria were offered the *Counterweight-Plus* weight management programme (figure 1), utilising a nutritionally complete low energy formula diet (figure 2) for 12-20 weeks, followed by structured food reintroduction of 2-8 weeks and an ongoing structured programme with monthly visits for long term weight loss maintenance for a further 6 months to facilitate the long-term health behaviour change.

Patient comments received at various phases:

Phase 1: TDR
"I have already stopped all of my diabetes medications that I have been taking for 20 years"

Phase 2: Food Reintroduction
"Knowing I can be truthful with my Dietitian as she does not judge me if I struggle, but makes me feel supported & encouraged"

Phase 2: Food Reintroduction
"Fantastic journey back to health"

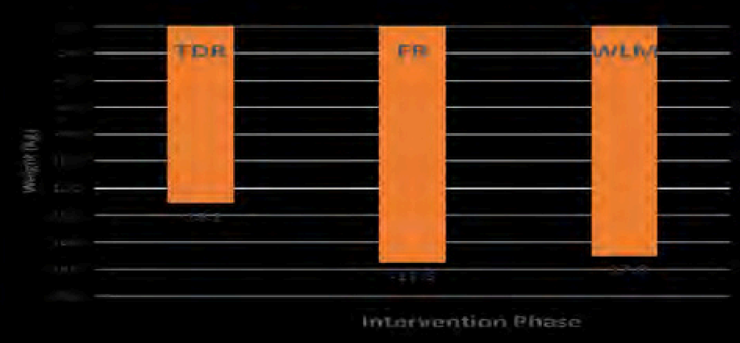
Phase 3: Weight Loss Maintenance
"Better understanding of my food choices, meal size & balanced diet"

Results

The outcomes for the Wales Remission service matched the co-primary outcomes of the DiRECT study, these being a reduction in weight of 15kg or more, and remission of diabetes, defined as HbA1c less than 48mmol/mol from baseline to month 12. Data was collected at baseline, end of Total Diet Replacement, end of Food Reintroduction and at 12 months.

Of the 44 patients who completed the 12 months, had a mean weight loss of 17kg at 12 months (chart 1). For patients with two hbA1c results available at 12 months, 87% had an improvement in the diabetes control from baseline. **73% lost ≥10kg, remission was achieved in 62% and 87% had an improvement in their diabetes**

UHB	No. recruited	No. completed	No. achieved HbA1c ≤48mmol/mol at 12 months	No. HbA1c ≥48 & lower than baseline at 12 months
CVUHB	16	6	5	0
ABUHB	26	6	4	1
BCUHB	30	17	12	2
HDUHB	15	15	6	4
Total	101	44	27	7



Discussion

Conclusion

In the principles of value-based health care the Diabetes Remission service is predicated on facilitating the best possible outcomes for people who have had T2D for <6years with the right interventions and contacts, at the right time and place, within the resources available, reducing waste, harm and variation. This service allows people living with T2D the opportunity to put it into remission & the hope is that is will be an additional offer within the dietetic service menu of nutritional therapy options available to support Self-management and reducing co-morbidities associated with diabetes.

Following the successful pilot we wish to enable the future 'once for Wales' approach to ensure people across the whole of Wales have access to support with achieving diabetes remission/ regression and management through medical nutritional therapy as an alternative to drug therapy. This programme is designed to improve health, reduce likelihood of people developing complications from diabetes & to support prevention of admission, thereby releasing bed capacity that would otherwise have been utilised by these patients. Along with reduction in medication costs, reduce the risk of hypoglycaemia and the consequences associated. The ability to offer patients the chance to achieve type 2 diabetes remission has been deemed a priority and a quality statement within Wales diabetes services led by National Strategic Diabetes network.

References:

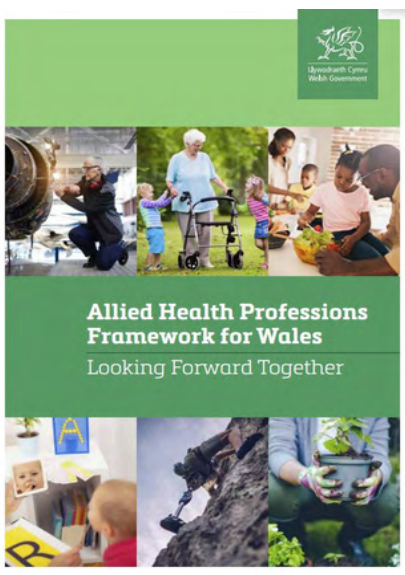
Demonstrating the Impact and Value of Allied Health Professionals Through Value-Based Healthcare in Wales

Christian Newman
National Allied Health Professions Advisor for Value Based Healthcare, Welsh Value in Health Centre
Deputy Head of Value Based Healthcare, Hywel Dda University Health Board
christian.newman@wales.nhs.uk

Background

The *Allied Health Professions Framework for Wales* (WG, 2019) recommends that Allied Health Professionals (AHPs) embed Value-Based Healthcare (VBHC) to demonstrate their impact and value (Figure 1). However, the adoption of VBHC by AHPs will be influenced by their perceptions. Despite this, there is an absence of published literature examining AHPs' perceptions of VBHC in Wales.

Figure 1: Overview of Allied Health Professions Framework for Wales



The Allied Health Professions framework describes the challenges that need to be addressed, **the value that AHPs offer, and the actions needed to help maximise their value and impact**.

Its purpose is to ensure:

- **Citizens achieve outcomes that matter to them** and experience the highest quality of care and treatment at all times.
- **Allied Health Professionals collectively and individually embed value-based health and care**. They apply their skills, experience and professional values to lead and deliver evidence-based care to improve the lives of citizens in Wales.

Aim

To investigate AHPs' perceptions of VBHC in Wales.

Method

An online self-administered questionnaire was designed to collect both quantitative and qualitative data from a diverse group of AHPs across Wales.

Results

A total of 117 responses were received from AHPs representing 8 of the 13 different professions classified as AHPs in Wales (Table 1). 97% (n=114) of respondents were employed in the National Health Service (Table 1). Responses were received from AHPs in every Health Board in Wales.

36% (n=42) of respondents agreed, and 18% (n=21) strongly agreed, that the value of interventions and interactions performed by their individual professions are difficult to measure and evidence using traditional approaches that focus on processes or outputs (Figure2). However, 44% (n=51) of respondents agreed, and 12% (n=14) strongly agreed, that VBHC will make it easier to demonstrate the value of the interventions and interactions performed by their individual professions (Figure3). Additionally, 45% (n=53) of respondents agreed, and 24% (n=28) strongly agreed, that VBHC will help AHPs articulate the value of their role (Figure4).

Table 1: Respondents demographics

Profession	**Count**	**Percent**
Art Therapist	1	1%
Dietitian	10	9%
Music Therapist	2	2%
Occupational Therapist	42	36%
Orthoptist	2	2%
Paramedic	9	8%
Physiotherapist	33	28%
Podiatrist	5	4%
Practitioner Psychologist	4	3%
Speech and Language Therapist	9	8%
Grand Total	**117**	**100%**
Type of organisation MAINLY work for	**Count**	**Percent**
NHS	114	97%
Other Public Sector	2	2%
Private Sector	1	1%
Grand Total	**117**	**100%**

Figure 2: Responses to the statement 'The value of interventions and interactions performed by my profession are difficult to measure and evidence using traditional approaches that focus on processes or outputs'

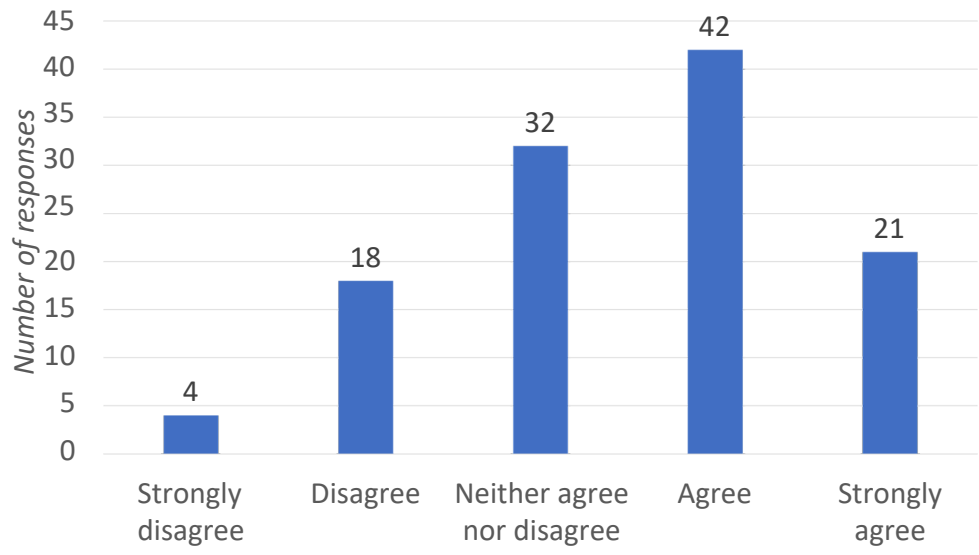


Figure 3: Responses to the statement 'VBHC will make it easier to evidence the value of interventions and interactions performed by my profession'

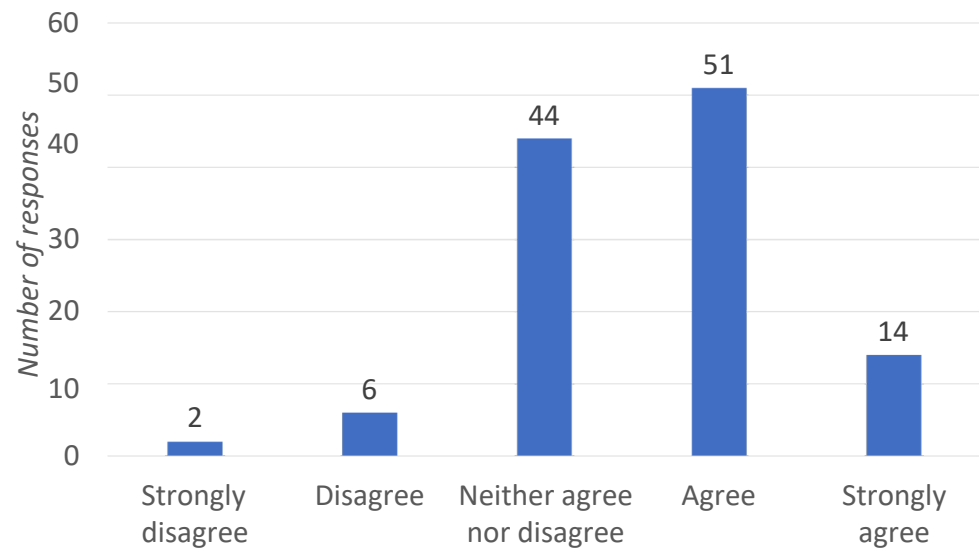
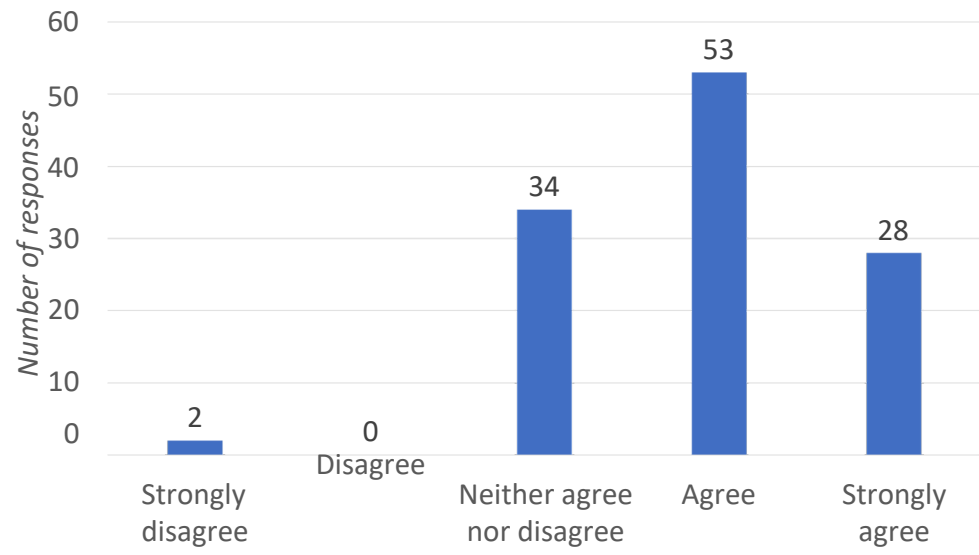


Figure 4: Responses to the statement 'VBHC will help AHPs articulate the value of their role'



Conclusion

The findings of this study highlight the challenges AHPs face in demonstrating the impact and value of their work using traditional approaches. However, there is optimism among AHPs that VBHC addresses these challenges by providing a framework that more effectively showcases their value. AHPs, health and care organisations, and professional bodies can use the insights from this study to support the adoption of VBHC, enabling AHPs to better demonstrate their contributions across the system, ultimately improving patient outcomes for the population of Wales.

References

Welsh Government. (2019). Allied Health Professions Framework for Wales. https://www.gov.wales/sites/default/files/publications/2020-02/allied-health-professions-framwework-for-wales.pdf

General Movement Assessment: Motor Optimality Score correlation with later Neurodevelopmental Outcome

D Paris[1], M Manton[3], S Maity[2], A James[2], A Allman[2]

[1]Department of Physiotherapy, [2]Department of Neonatology Aneurin Bevan UHB

[3]Department of Physiotherapy, Cwm Taf Morgannwg UHB

Objectives

- General Movement Assessment (GMA), in particular absent Fidgety Movements (FM-) at a corrected age of 3-4 months, has improved early identification of infants at high risk of adverse neurodevelopmental outcomes[1]
- Motor Optimality Score-revised (MOS-R) is a more in-depth analysis of infants' motor repertoire which has been shown to correlate with the degree of future motor difficulties in children with emerging adverse neurodevelopmental outcomes[2,3]
- We compared MOS-R with motor outcome in our cohort

Methods

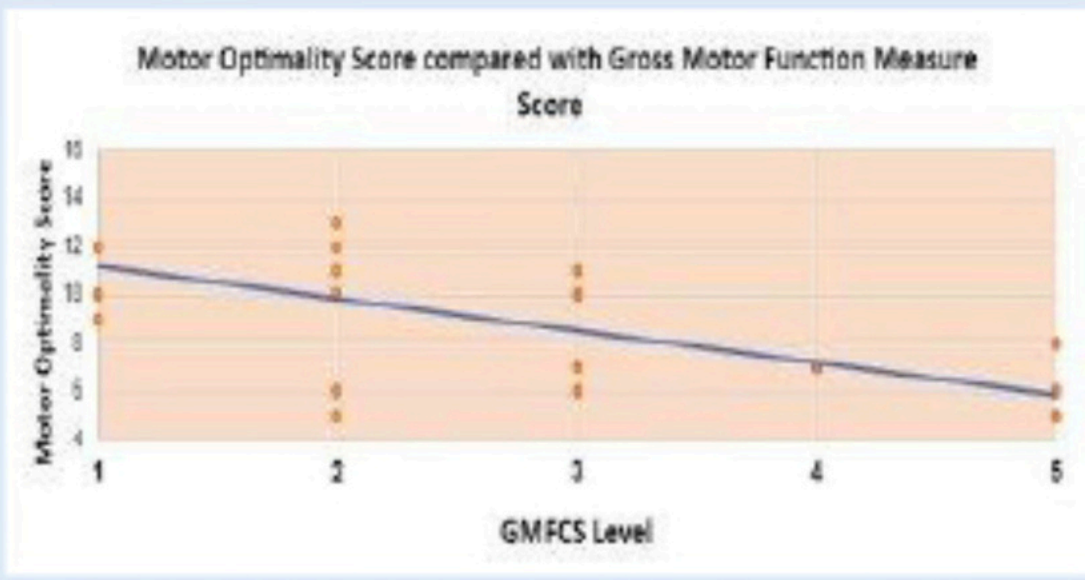
- Infants born preterm <1500g or with significant hypoxic ischaemic encephalopathy at our Level 3 Neonatal Unit & who had been classified as FM- on GMA video analysis were retrieved from neonatal databases
- MOS-R was completed by reanalysing their previous GMA videos
- MOS-R scores range from 5-28 maximum
- Score <8 indicates increased risk of significant adverse neurodevelopment outcome[2,3]
- Motor disability level was measured using the age-appropriate Gross Motor Functional Classification System score (GMFCS)

GMFCS Levels

Images used with permission © Bill Reid, Kate Willoughby, Adrienne Harvey & Kerr Graham, The Royal Children's Hospital Melbourne

Results

- 30 infants previously identified FM- were retrospectively scored for motor optimality using MOS-R
- All had a GMFCS score recorded between 2-6 years



All 30 children had neurodevelopmental difficulties:

- 22 (73%) Cerebral Palsy
- 8 (27%) Global Developmental Delay

14 had MOS-R <8

- 12/14 were GMFCS Level 3, 4 or 5 showing significantly reduced mobility
- 2/14 were GMFCS Level 2; both had disabling autistic spectrum difficulties

16 had MOS-R >8

- 13/16 were GMFCS Level 1 or 2 showing higher mobility level
- 3/16 were GMFCS Level 3

Conclusions

GMA and the absence of FM is now widely adopted as a means of early identification of infants at high risk of adverse neurodevelopmental outcome. MOS-R can further refine the degree of motor disability. Although small, our cohort demonstrates a correlation between low MOS-R and future greater motor disability in infants classified as FM- on GMA.

As well as advocating GMA for all high risk neonates, we recommend motor optimality scoring to predict the degree of future mobility deficit, therefore enabling more individualised targeted early intervention therapy for high risk infants and families and support for guiding parental expectations.

References

[1]Novak, I. et al. Early, accurate diagnosis & early intervention in cerebral palsy. JAMA Pediatr. 171, 897–907(2017)

[2]Einspieler, C. et al. Cerebral palsy: early markers of clinical phenotype and functional outcome. J. Clin. Med. 8(10):1616(2019)

[3]Örtqvist, M. et al. Early prediction of neurodevelopmental outcomes at 12yrs in children born extremely preterm. Pediatr Res. 91(6):1522-1529(2022)

Contact: debbie.paris@wales.nhs.uk

Bridgend COPD Team Home Exercise Programmes (HEP)

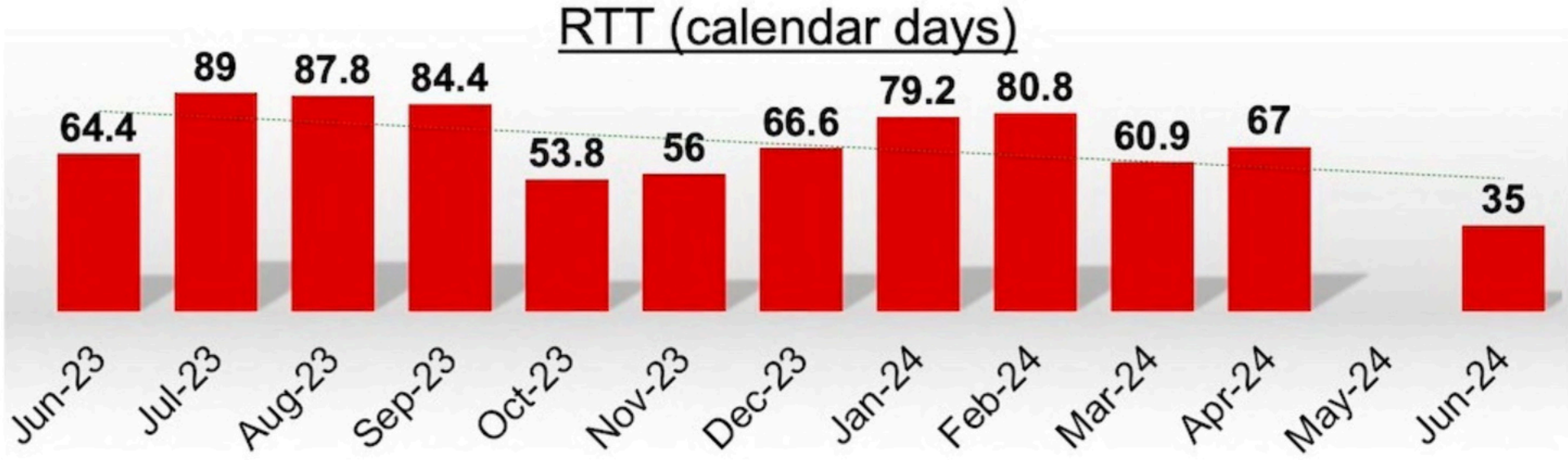
Elaine Sutherland (elaine.sutherland@wales.nhs.uk)
Sarah Bishop (sarah.bishop4@wales.nhs.uk)

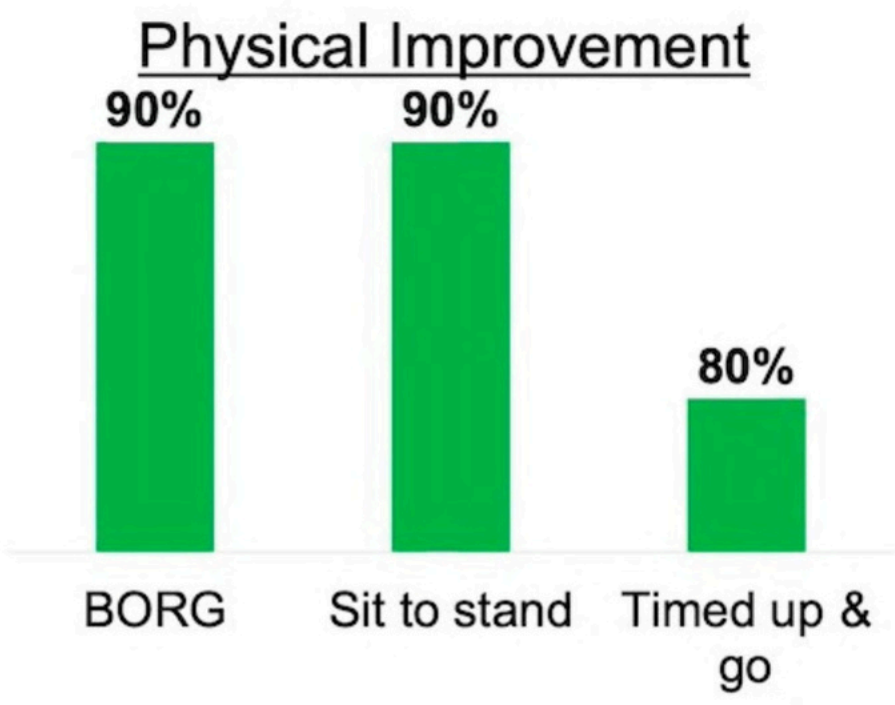
Aim 1: Achieve referral to treatment time (RTT) for early HEP within 4 weeks from start of COPD exacerbation (as per national guidelines).

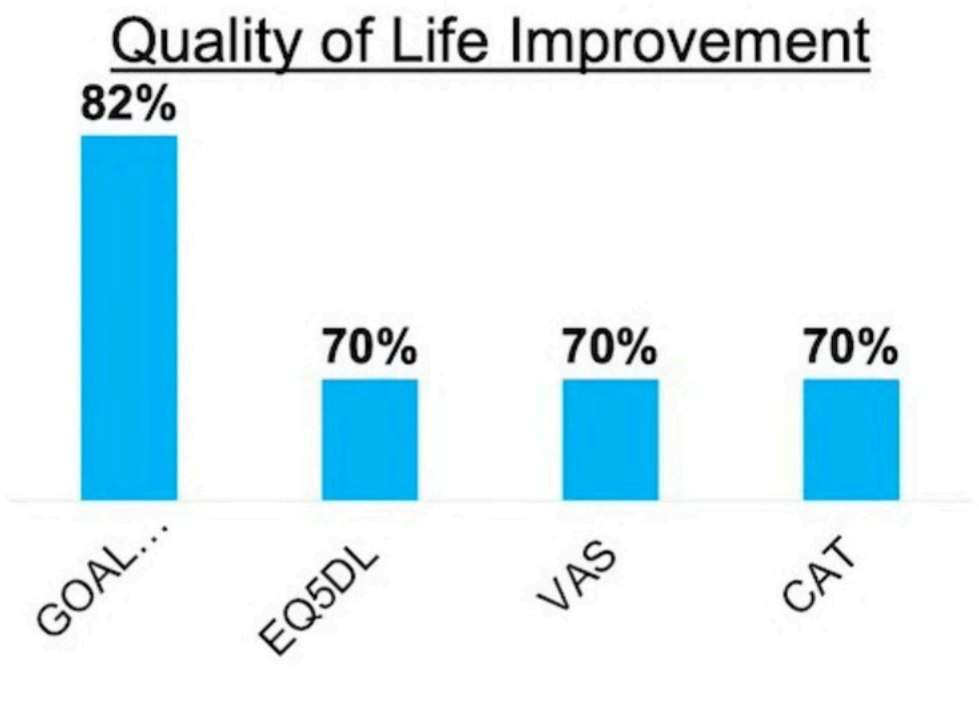
Method: Introduction of robust referral criteria. Patient engagement ascertained through information leaflets and phone calls to optimise use of technician time. Technician delivered individualised HEP twice a week for 6 weeks.

Outcome: Aim almost achieved at 1 year of service delivery – early HEP RTT reduced to just over 4 weeks. (This has since been achieved). Significant PROM improvements achieved, demonstrating effective service delivery with 100% patient satisfaction.

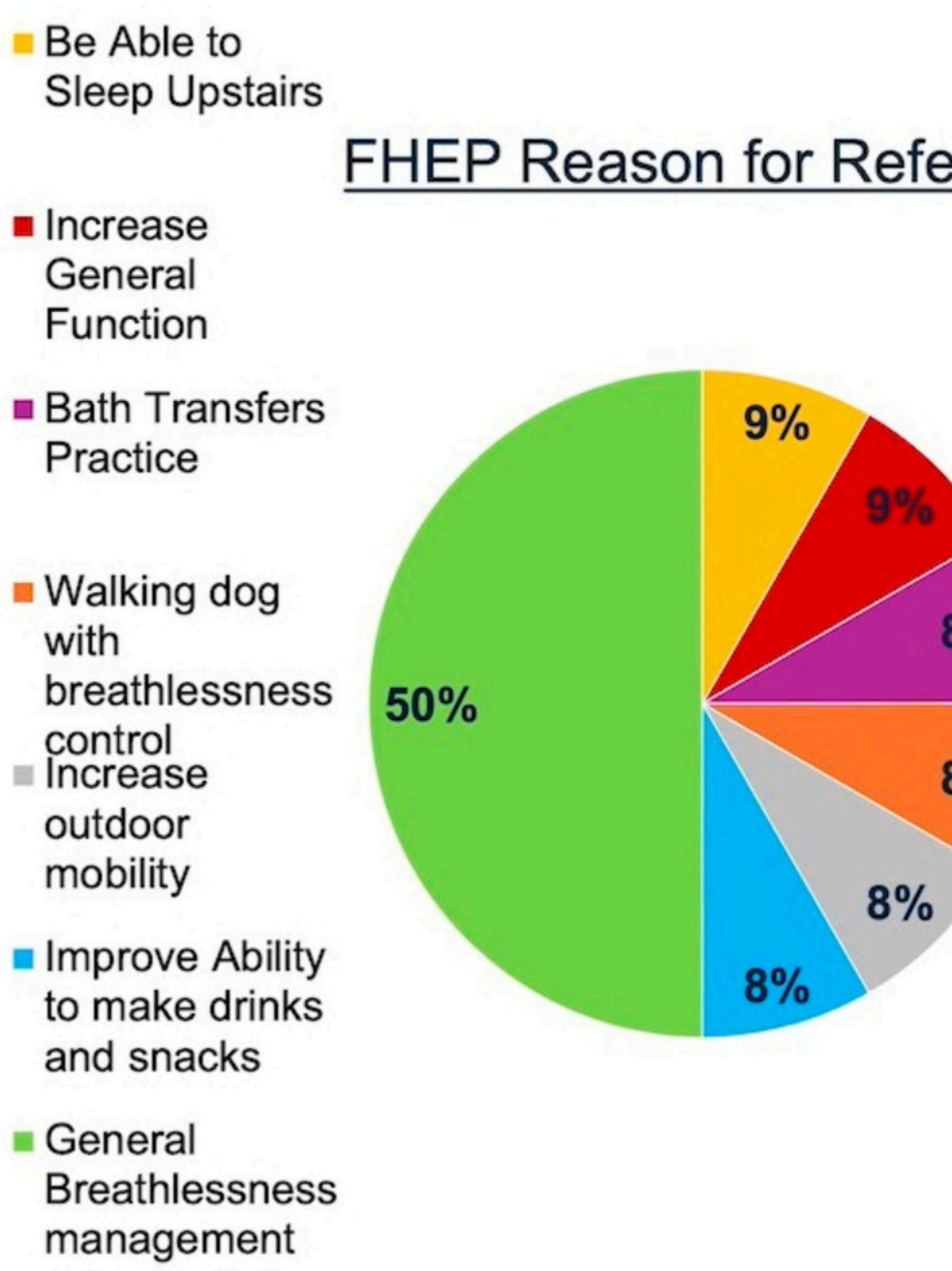
Future: Continue to deliver tailored HEP for patients within 4 weeks of COPD exacerbation.







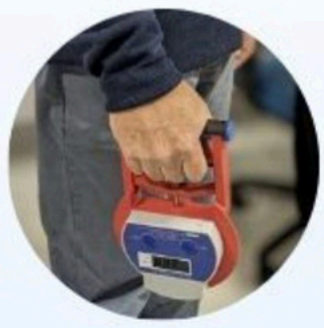
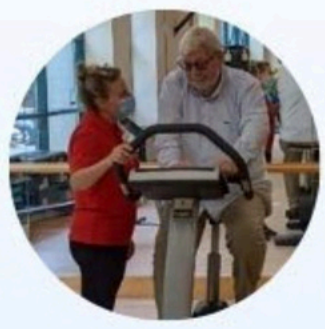
Aim 2: Set up and provide a functional goal-driven HEP for patients who are unable to complete a traditional HEP of strength and cardiovascular exercises.
Method: 'Functional HEP' (FHEP) planned using a PDSA cycle, referral criteria devised, and suitable patients referred.
Outcome: Individualised FHEP delivered to 12 patients. 100% clinician and patient satisfaction.
Future: Continue with FHEP delivery. Plan to introduce goal attainment PROM and decide on a suitable physical PROM.



A CANCER PREHABILITATION SERVICE EVALUATION

Authors
Jemima Bevan RD MSc, Joshua Tipple MCSP BSc, Erica Thornton MSCP BSc

Affiliations
Cardiff and Vale Univeristy Health Board

INTRODUCTION

Prehabilitation aims to support people with cancer prepare for treatment through the needs-based prescribing of exercise, nutrition and psychological interventions [1].
A reduced length of hospital stay, improved functional capacity and reduced rate of complications are just some of the evidenced benefits of multi-modal prehabilitation interventions [2,3,4]. However, due to the novel nature of this area in clinical practice, clinical guidelines are still in their infancy and there is not yet a consensus on the most effective delivery of prehabilitation interventions.

The Prehab2Rehab service started accepting referrals in 2021 and has since grown significantly to support people from six different tumour sites. It provides preparatory interventions to people awaiting treatment for Cancer across multiple areas of South Wales. This therapy led service consists of physiotherapists, dietitians, an occupational therapist and therapy assistant practitioners. It was one of the first of its kind in the UK and is the largest in Wales. The service covers a diverse geographical area, it is therefore crucial we strive to provide valuable and equitable support to all of our service users, irrespective of where they live.

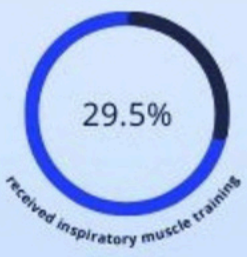
OBJECTIVE

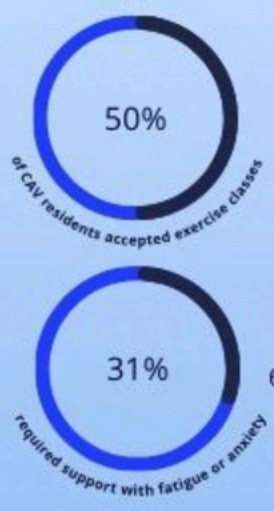
To investigate the effectiveness of the service for people with cancer through key clinical outcomes and operational information, and use this information to guide service development.

METHODOLOGY

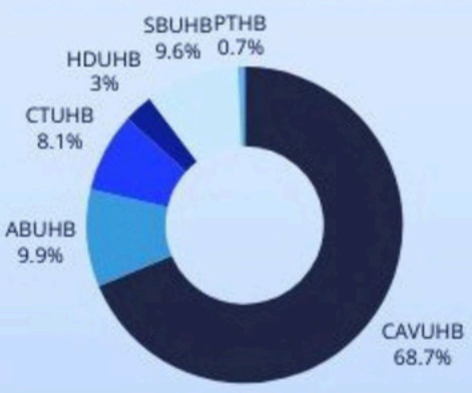
Key clinical outcome data was collected from people at initial assessment, and at the last contact prior to cancer-treatment (where possible). Clinical data from January 2023 to June 2024 was extracted from an electronic patient record using reports created in collaboration with software developers. Attendance and engagement data was gathered using business intelligence software. This raw data was then synthesized and analysed by the lead therapists. 1107 people were seen in the service in this timeframe, of which, 604 people were included in the final analysis and met the criteria of being discharged from the service within this timeframe.

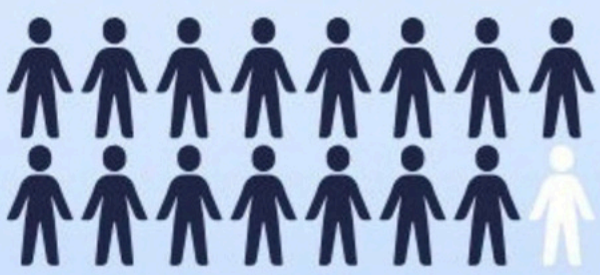
RESULTS





Referrals depicted by residential area

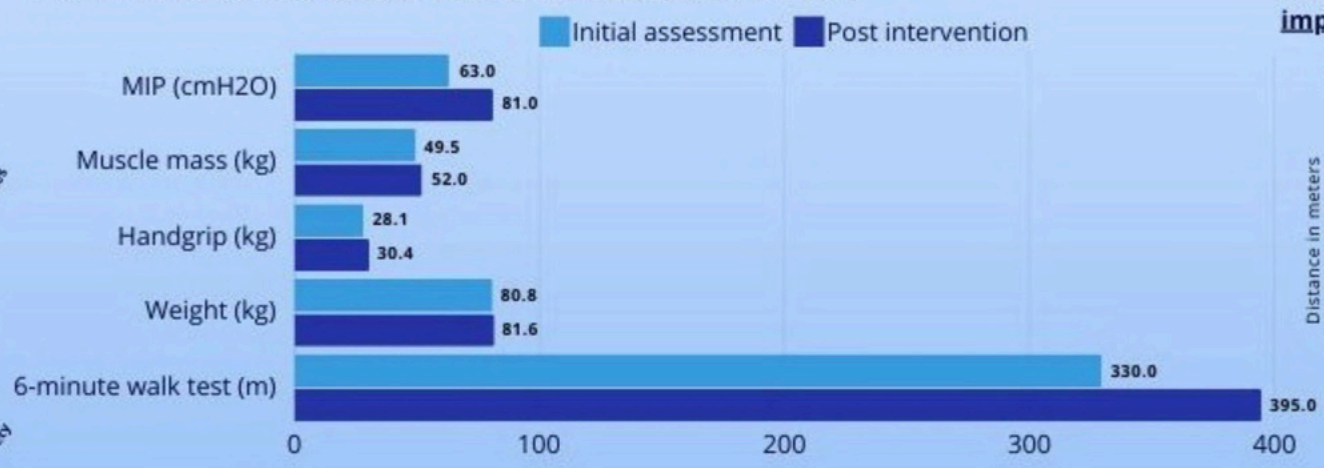




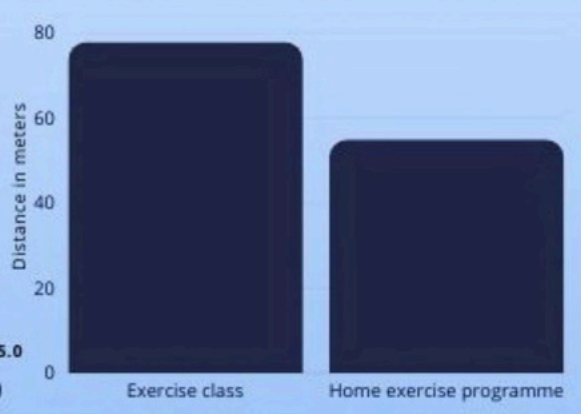
98.5% of people reported they were either **likely or extremely likely to recommend our service** to a friend or family member in a similar situation

Average increase in perception of own health obtained using a visual analogue scale

Key clinical outcome measures before and after prehabilitation



Comparison of 6-minute walk test distance improvement between exercise interventions



ANALYSIS

There was an overall improvement in physical function and nutritional status. By improving muscle mass and 6-minute walk test distance, individuals are at a lower risk of sarcopenia. Evidence shows that sarcopenia is associated with decreased survival rates in people with cancer [5].

Improvement in physical function was greatest in the cohort of people attending supervised exercise classes, compared to those following a home exercise programme. At present, over 30% of people referred to our service do note reside locally, putting them at a disadvantage to the full benefit of interventions on offer.

An improvement was also demonstrated in peoples perceived level of health before and after prehabilitation, suggesting an improved quality of life.

A particularly encouraging finding for the team was the high percentage of people who found value in our service by confirming they would recommend our service to others.

CONCLUSION

The current service model has been shown to be effective for the population of South Wales. Offering a range of interventions from a multi-disciplinary team is necessary to meet the range of needs in this group.

Localising services to enable an equitable offer of exercise classes to people living across all postcodes in South Wales is a priority. We are now working alongside past and current service users to co-produce future service developments. This will ensure that our therapy interventions are patient-centred and continue to support people living with and beyond cancer.

To find out more about Prehab2Rehab, please visit the "preparing for cancer treatment" pages on www.keepingmewell.com

REFERENCES

1. Principles and guidance for prehabilitation within the management and support of people with cancer In partnership with Acknowledgements. (n.d.). Available at: https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/13225-source/prehabilitation-for-people-with-cancer.
2. Johanna, C., Enrico Maria Minnella, Coca-Martinez, M., Wouter, D., Regis, M., Awasthi, R., Martínez-Palli, G., López-Baamonde, M., Sebio-Garcia, R., Carlo Vittorio Feo, Rooijen, van, Marijke, J., Rasmus Dahlin Bojesen, Ismail Gögenur, Edwin, Carli, F. and Gerrit Dirk Slooter (2023). Effect of Multimodal Prehabilitation on Reducing Postoperative Complications and Enhancing Functional Capacity Following Colorectal Cancer Surgery. doi:https://doi.org/10.1001/jamasurg.2023.0198.
3. Minnella, E.M., Awasthi, R., Loiselle, S.-E., Agnihotram, R.V., Ferri, L.E. and Carli, F. (2018). Effect of Exercise and Nutrition Prehabilitation on Functional Capacity in Esophagogastric Cancer Surgery. JAMA Surgery, 153(12), p.1081. doi:https://doi.org/10.1001/jamasurg.2018.1645.
4. Lambert, J.E., Hayes, L.D., Keegan, T.J., Subar, D.A. and Gaffney, C.J. (2021). The Impact of Prehabilitation on Patient Outcomes in Hepatobiliary, Colorectal, and Upper Gastrointestinal Cancer Surgery: A PRISMA-Accordant Meta-analysis. Annals of Surgery, [online] 274(1), pp.70–77. doi:https://doi.org/10.1097/SLA.0000000000004527.
5. Arends, J. (2023). Malnutrition in cancer patients: Causes, consequences and treatment options. European Journal of Surgical Oncology, [online] 50(5), p.107074. doi:https://doi.org/10.1016/j.ejso.2023.107074.

How do Dietitians measure their impact on the care of patients?

A qualitative evaluation of dietitian's perception of importance, understanding and practices of outcome measurement, exploring two areas of clinical practice.

Introduction

Dietitians in the UK have had a structured care process to follow since the introduction of the Dietetic Model and Process in 2006 (British Dietetic Association (BDA), 2022). Measurement of Outcomes is a key part of the process with the accompanying Outcomes Framework updated by the BDA in 2021. Despite this collection of outcomes is still not routine in clinical dietetic practice.

Understanding of the practical implementation of Patient Reported Outcome Measures is developing. Clinician perceptions to their use have been explored in a number of clinical groups and specialities but none focus specifically on dietitians.

Those looking at dietetics have tended to focus on outcome measures in a clinical sense, evaluating the effectiveness of dietetic consultations and identifying a need for further research on the impact of a range of parameters. (Mitchell et al, 2017). Several comment on challenges faced including dietetic care within the multidisciplinary setting and the diverse nature of dietetic practice (Hickman et al, 2015; Clark et al, 2021).

This study aims to explore the perceptions of Dietitians working in an NHS Health Board in the United Kingdom regarding the use of outcome measures to identify challenges faced and propose ways to overcome them.

Keywords: Dietetic Practice, Outcome Measures, Dietitians perceptions, Clinical Impact, Practice Effectiveness

Morris, J. and Gallimore, K.
Centre for Nutrition and Dietetics, Prifysgol Fetropolitan Caerdydd/Cardiff Metropolitan University. CF5 2YB
Tachwedd / November 2022
Contact: Kgalimore@cardiffmet.ac.uk

Method

Qualitative methodology based on grounded theory was used to conduct semi-structured interviews with 16 dietitians, working within two different clinical areas.

Interviews were recorded and anonymised transcripts generated which were verified by each participant. Interviews were conducted by one researcher who was known to the participants but purpose and open exploratory nature of the interviews was fully explained.

Transcripts were subject to thematic analysis to identify key themes. Post analysis discussion with another dietetic manager was carried out to validate findings.

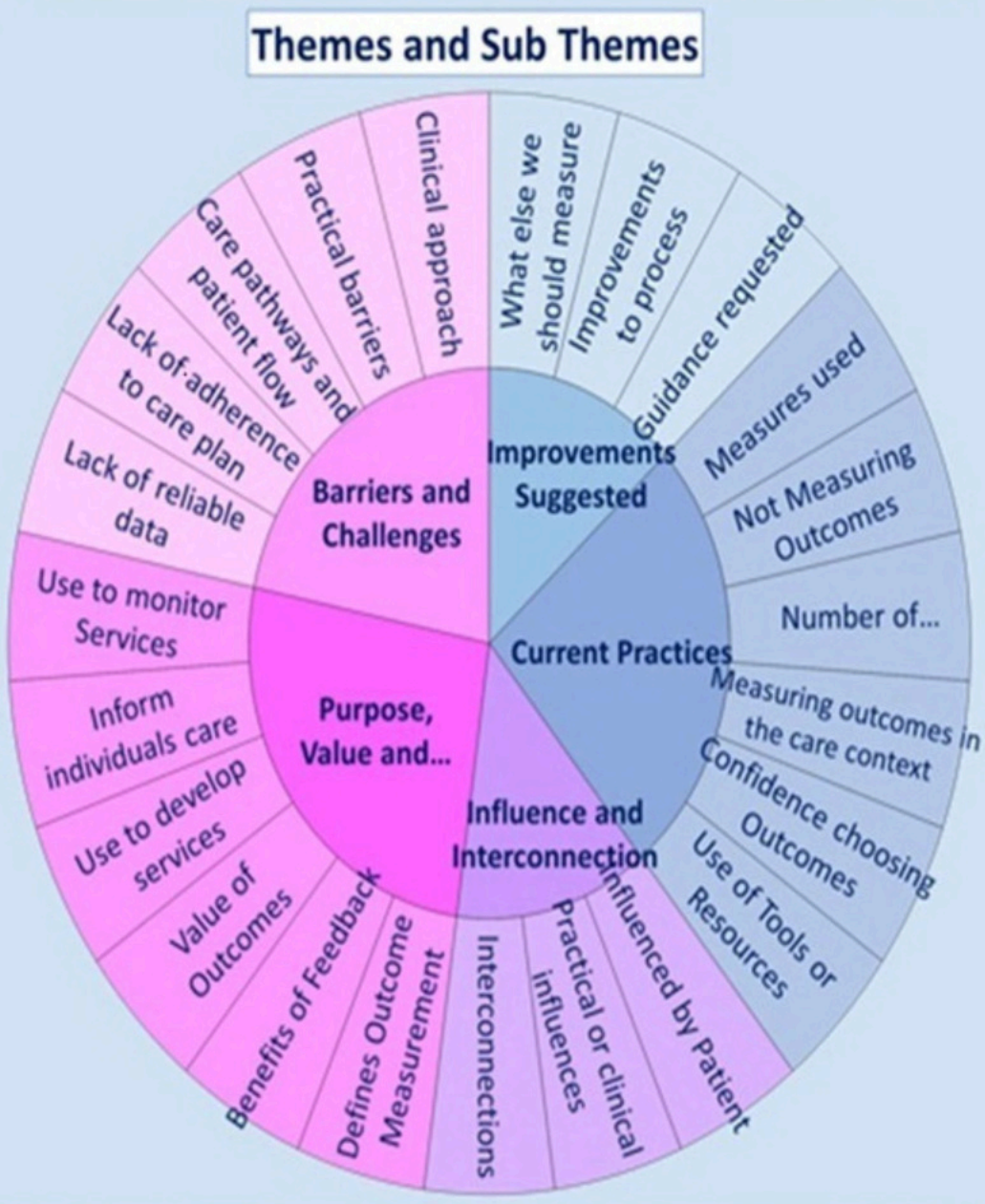
Findings

Five key themes emerged – Current Practices, Proposed Improvements, Purpose and Impact, Influences and Interconnections and Barriers and Challenges.

All participants identified that outcome measures were important to measure benefit to patients and justify health professional's time. Uses identified were to provide feedback to individuals on their practice and deploy staff differently within the service. Other benefits include improved job satisfaction and promoting the value of the profession.

Barriers or challenges primarily related to lack of or validity of measures. Some patient groups such as those receiving palliative care, were considered more difficult to select measures for.

Themes and Sub Themes



Recommendations and Conclusions

A broader list of outcomes for dietitians to use would enable appropriate outcomes to be selected for a greater variety of clinical interventions, capturing high impact measures to justify investment in staffing alongside softer measures to provide timely and rewarding feedback to the dietitians and their patients as part of routine practice.

References

- British Dietetic Association. <The Model and Process | British Dietetic Association (BDA)> Accessed [August 16th 2022]
- British Dietetic Association. <Outcomes | British Dietetic Association (BDA)> Accessed [August 16th 2022].
- Clark PW., Williams LT., Kirkegaard A., Brickley B. and Ball L. (2021) Perceptions of Private Practice Dietitians Regarding the Collection and Use of Outcomes Data in Primary Healthcare Practices: a qualitative study. J Hum Nutr and Diet. [Preprint]. doi:10.1111/jhn.12950.
- Hickman, IJ., Cotugno, J., Lassemillante A-CM. and Furguson, M. (2015) Am I Making a Difference? Measuring dietetic outcomes in clinical practice. European Journal of Clinical Nutrition. **69**, 1181-1183.
- Mitchell LJ., Ball LE., Ross LJ., Barnes KA. And Williams LT. (2017) Effectiveness of Dietetic Consultations in Primary Health Care: A systematic review of randomized controlled trials. Journal of the Academy of Nutrition and Dietetics. **117**(12); 1941-1962.

The content is framed around 5 themes.

1. Enhancing daily living
2. Adapting the everyday environment
3. Maximising psychological wellbeing
4. Maximising physical wellbeing
5. Supporting families & carers as equal partners

The Challenge

Each participant will have different goals, priorities and needs

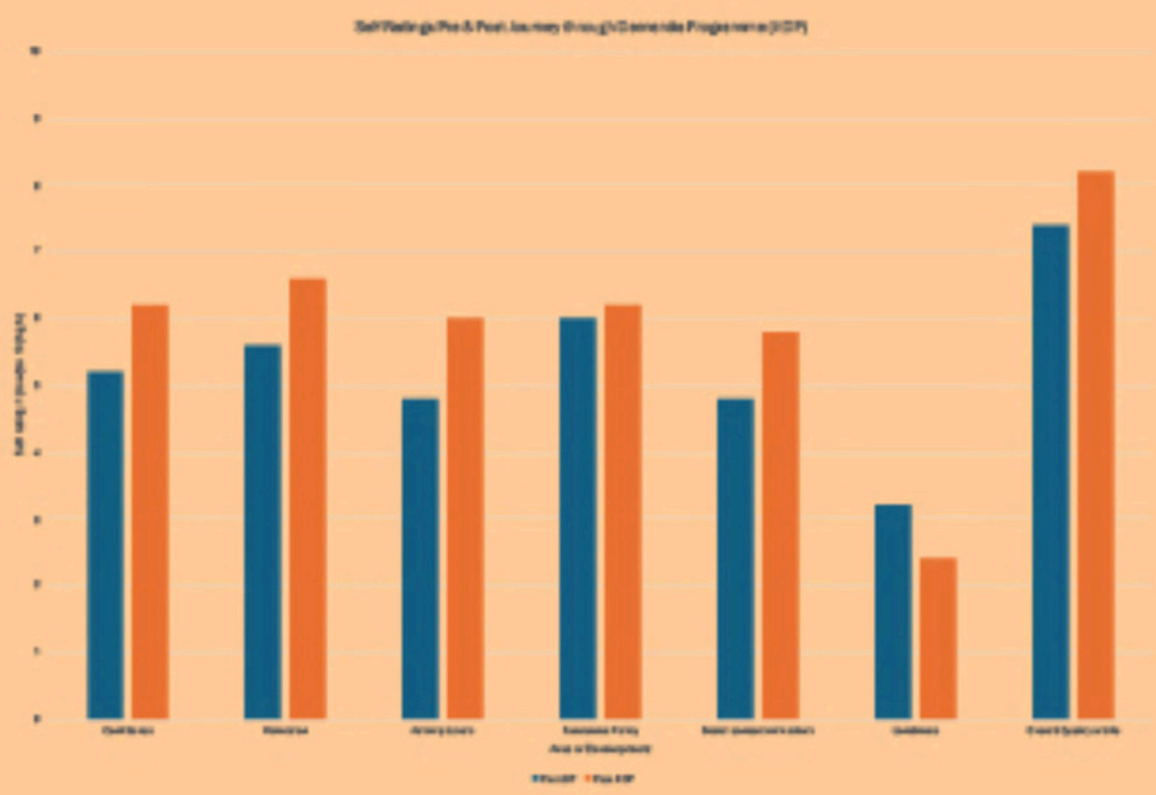
The Adapted Recovery Star (2019)

- Allows patients to self-rate (subjective view of difficulties for each component)
- Allows patients to self-rate their levels of confidence, motivation, activity levels, functional ability, social contact with others, loneliness and overall quality of life.
- Completed at first & last session (identifying change over time)
- Provides a visual representation of their journey.
- Piloted with 2 cohorts successfully.

Journey through Dementia Programme

Demonstrating Impact

A structured, menu led, occupation focused, post diagnostic group designed by people living with a dementia diagnosis & Occupational Therapists



"Doctors don't tell you how to live with it [dementia] but this group does."

"I felt it [the programme] prepared me for the future and thoroughly enjoyed the sessions."

"My loved one has looked forward to this group every week, it's become an important part of their routine."

Dementia Wellbeing Community Team

Karen Shearsmith-Farthing - Advanced Practice Occupational Therapist

Email: Karen.Shearsmith-farthing@wales.nhs.uk

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TRACHEOSTOMY CARE IN THE REHABILITATION SETTING

A MULTIDISCIPLINARY APPROACH

Lauren McMunn (Physiotherapist) & **Sarah Appleton** (Speech and Language Therapist)

Introduction

As an MDT in the neurorehabilitation unit within Llandough hospital, we aim to enhance patient experience by focusing on individualised care, equitable treatment, and the expertise of staff. This includes patients both with and without tracheostomies.

This project identified discrepancies between these two groups and sought ways to improve equitable rehabilitation.

Aim

The project aims were to explore the challenges and implement changes to enhance safety, ensure equitable treatment, and boost staff confidence and knowledge, providing high-quality care for tracheostomy patients in the neurorehabilitation unit at University Hospital Llandough.

Timeline / Background

Prior to 2020, Neurorehabilitation was located in Rookwood Hospital, and this included medically stable tracheostomies whose care was medically led.

During the COVID pandemic of 2020, tracheostomy beds were closed.

In 2021, the Neurorehabilitation Unit in Rookwood Hospital relocated to West 10 in Llandough Hospital.

Following the move, two tracheostomy beds were opened, and a new model of MDT care was commenced.

Tracheostomy Capacity in Neurorehabilitation:

West 10 NRU are able to support:

- Up to two trache patients at one time
- Can be weaning or non-weaning

There is a high demand for these beds; including ABI / TBI / Stroke / Prolonged disorders of consciousness (PDOC).

When both patients are non-weaning, it can cause delays in accessing specialist services.

NB: Our sister unit in Neath Port Talbot, does not take Tracheostomies

Hurdles identified for our patients:

The two main hurdles identified for our patients were:

- An increase in length of stay
- Variable patient experiences due to inequitable opportunities

Method

We established a working group to explore patient challenges and the impact on staff using a PDSA cycle.

We identified

- a need to upskill across therapies
- variability in approaches
- inconsistent documentation
- low staff confidence
- unclear role definitions

In response, we developed

- decision trees
- standardised risk assessments
- improved documentation
- To further support staff, we implemented a structured ward round with therapy champions providing guidance.

This approach aimed to ensure consistent, high-quality care, enhance staff confidence and clarify roles, ultimately improving patient outcomes and the overall experience in the neurorehabilitation unit.

Impact

The mentorship and learning initiatives led to improved collaboration within the MDT, fostering a clear and standardised approach to care. This enhanced access to therapy and therapeutic areas for patients and raised the overall standard of care. With nursing and therapy tracheostomy champions in place, staff confidence grew, ensuring consistent and high-quality care. AHP training is now regularly delivered, further reinforcing these improvements. Additionally, the implementation of standardised discharge paperwork and handover processes has streamlined transitions of care, reducing errors.

Overall, these changes have significantly improved both patient outcomes and staff satisfaction in the neurorehabilitation unit.

Learning shared across Wales

This learning can be applied across Wales by emphasising the benefits of collaboration, mentorship and upskilling within MDTs. Working as a cohesive interdisciplinary team with shared goals and a vision within a service leads to improved patient and staff experience, outcomes and service delivery. Sharing skills within teams to nurture relationships and build links will ultimately lead to a more equitable and efficient healthcare system across Wales.

ARE ALLIED HEALTH PROFESSIONALS NEEDED IN ACUTE ONCOLOGY?

Sally Brown: Acute Oncology Lead Occupational Therapist
Suzie Leverton: Highly Specialist Physiotherapist Acute Oncology
Rebecca Christy-Harrold Acute Oncology Lead Dietitian

In 2022 an Occupational Therapist, Dietitian and Physiotherapist were funded to join the Acute Oncology (AO) team in Cardiff and Vale UHB. This is the first team of its kind within Wales to appoint AHPs as specialists within a district general hospital. After appointment the AHP team needed to fully understand the potential of what the service provision could be from each profession, and how they could best meet the patients needs. This lead to the creation of a therapy screening tool to start identifying the need for AHPS within acute oncology.

Method

- **Extensive research and benchmarking of service provision and intervention types delivered by each profession to aide screening tool development. Multiple revisions to enhance sensitivity and to ensure it was capturing the correct information.**
- **Blanket face to face screening of all AO patients within 24 hours of referral to identify AHP need and to start early intervention.**
- **Following screening patient needs were themed into 'CORE' therapy input and 'SPECIALIST' therapy input differentiating the enhanced service AHPs as specialists could provide.**
- **The screening tool included questions around frailty, deconditioning and sarcopenia.**

2024 Results to date

77%
Of total Acute Oncology patients were screened by the AHP team.

43%
Had physiotherapy needs

46%
Had Dietetic needs

31%
Had Occupational Therapy needs

19%
Had Specialist needs around oncological symptom management

Conclusion

The establishment of a face-to-face multi professional screening tool has shown a significant percentage of acute oncology patients have AHP needs. Frequently these were patients that wouldn't have otherwise been seen by an AHP as had specialist needs only. Having AHPs in acute oncology has proven an asset allowing early, patient centred and holistic assessment with focus on maintaining quality of life. However with only having one of each profession has lead to limitations with service provision. Future aims would include enhanced data collection and understanding of unmet need to enable a business case to expand the service provision to address this limitation.

September 2024

Feasibility of the ***Kate Malcomess Care Aims Intended Outcome Framework ©*** in improving care. Phase 3 of a spread and scale in acute Speech and language therapy – final implementation

Understanding the problem

The demand for Speech and language therapy in the UK is increasing, and urgent action is needed to address this demand. The Royal College of Speech and Language Therapists (RCSLT) has identified funding, workforce planning, and access to professional development as key obstacles to meeting this demand. One potential solution is to adopt the Kate Malcomess Care Aims Intended Outcome Framework ©. This framework empowers clinicians to clearly define treatment goals, target what matters to the patient, establish realistic expectations, and measure effectiveness to provide more patient-centered care. By focusing on care in this manner, it can be more efficient and effective, resulting in shorter episodes of care and optimising the limited clinical resources available.

Aim: What are you trying to accomplish?

The project started with a pilot test last year at one hospital, where we focused on one group of patients as a trial (Acute medical). We tried different ways to improve their care, and when the test ended, we found that these patients needed fewer follow-up appointments. Follow-up visits were reduced by 50%. Avoiding unneeded follow-ups helped patients get better care sooner.

In the second phase, we applied this learning and included all inpatients including those with stroke and other medical problems. This led to a 25% drop in follow-up appointments overall.

In the final phase, the goal was to use what we learned and apply it to all teams in five hospitals. We wanted to get the same results faster, keeping what worked and stopping what didn't with the hope of achieving a 25% reduction in follow ups and improving clinician reported experience of care quality.

Measures: How will we know a change is an improvement?

Measures:

- **Total number of follow ups contacts across acute SLT combined measured in weekly intervals**

Changes: what changes can we make that will result in an Improvement?

The team completed refresher training on the Kate Malcomess Care Aims Intended Outcome Framework. To make this model of care work better, we switched from using paper and voicemail referrals to using carry phones for real-time communication (PDSA 1). We told the wards about this change (PDSA 2) and, where possible, redirected calls to the main admin team (PDSA 3).

We also updated and digitised assessment and treatment notes (PDSA 4) and began holding weekly meetings (PDSA 5) to talk about cases and make sure everyone is using the same reasoning. Now, we're also tracking clinical outcomes for analysis to help improve practice (PDSA 6). We've also gathered feedback from staff about their experiences using the care aims system.

Results

- The rollout has shown similar results across all sites, with a drop in the average number of follow-up appointments. Although we need more data since the final site was rolled out in June, current predictions suggest we'll see around a 50% decrease in follow-ups across the service each week.
- Clinicians feel better about their own wellbeing, and they are using more time for clinical training and personal development. They have a positive view of the changes, and care feels more focused on the patients.
- We can now measure the impact of care using goal achievement and the Therapy Outcome Measure (TOMS).

Results

Figure 1 – Referrals across all sites have not changed (demand remains the same)

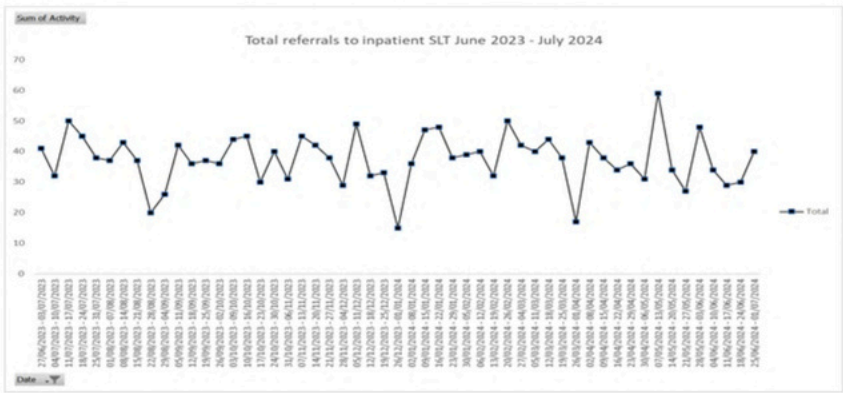
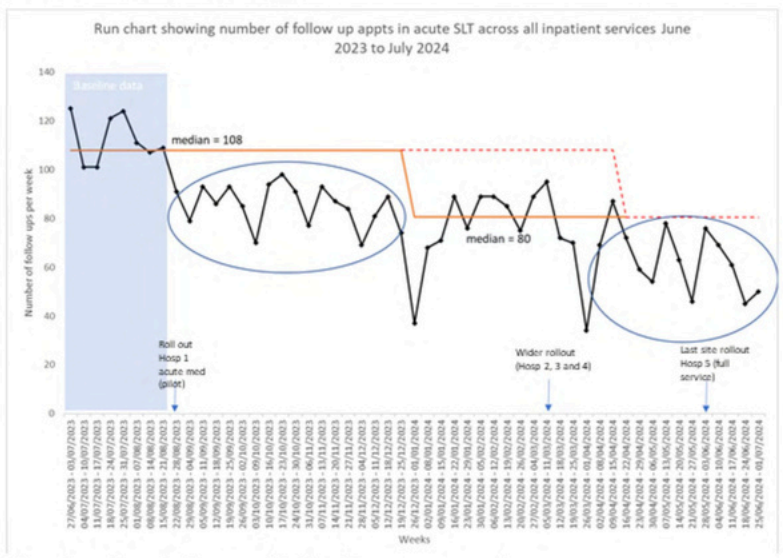


Figure 2 – Follow up contacts all acute services June 2023 to present day. Capacity is much improved.



Qualitative feedback from clinical team members

"It makes it easier to justify our clinical reasoning to other professionals"

"This has helped focus my clinical decision making and question why I'm making certain decisions regarding patient reviews, becoming more patient-focused and time-efficient"

"It has provided a structured framework for me to reflect on my practice, particularly during clinical supervision with my peers. As a result I am clearer in my clinical reasoning for the interventions I carry out with patients and I feel much more confident that the impact I'm having is positive, person-centred and time-efficient."

"Helped me prioritise my caseload more effectively. I feel my patient contacts are more meaningful and time efficient"

Reflection and the next steps

This project builds on last year's pilot and phase 2, showing that the Care Aims Intended Outcome Framework can work well in acute Speech and Language therapy. With the NHS budget under pressure and a growing demand for Allied Health Professionals (AHPs), making changes can be challenging. Overcoming these challenges has been a key learning point, using Kotter's 8-step model to guide the process with regular updates and communication.

The project has shown positive results, motivating staff and showing that care and efficiency can improve without needing extra resources. Although we have needed to hire external locums in the past, this new approach has reduced the need for locum cover, and no locum expenditure is expected for FY 24/25. The next step will be to review our clinical outcomes and use improvement methodology to make further optimisations.

Scan to view ongoing improvement projects:

SCAN ME

Tom Richards
Professional Manager Speech and Language Therapy
iCTM Improvement Community of Practice. Scottish improvement leader alum.
Thomas.Richards@wales.nhs.uk

Cysylltu Trawsnewid Meithrin iCTM Connect Transform Motivate

Improvement

Orthopaedic Prehabilitation: *The impact and value of delivering supervised Prehabilitation support to patients waiting Knee and Hip joint replacement surgery*

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Chris Lambert, Alice Mayo, Nadia Kudrjasova

Background and objectives

Swansea Bay University Health Board (SBUHB) has established an Orthopaedic Prehabilitation programme, providing multidisciplinary therapy to optimise the health of patients awaiting knee and hip arthroplasty. The programme aims to improve patients' fitness before surgery and runs alongside the Welsh Government-sponsored OWLi project, which is researching the impact of extended waiting lists on patient health.

The objective of this service evaluation is to demonstrate the performance and value of the Ortho Prehab service and assess its impact on optimising health outcomes.

Method

We identified over 300 patients on the Orthopaedic waiting list with BMI scores exceeding SBUHB's recommended surgical cut-off (BMI ≥ 40 kg/m²). Additionally, 600 patients self-reported a decline in mobility and function, requesting Physiotherapy support.

These patients were invited to the Prehabilitation service for assessment and triage into appropriate Allied Health Professional (AHP) interventions. A patient-centred, goal-setting approach was utilised to determine the most suitable treatment, which included weight management groups, individual therapy, mixed exercise classes, or community appointments. Baseline and final Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) were collected via an innovative digital platform to monitor progress and outcomes.

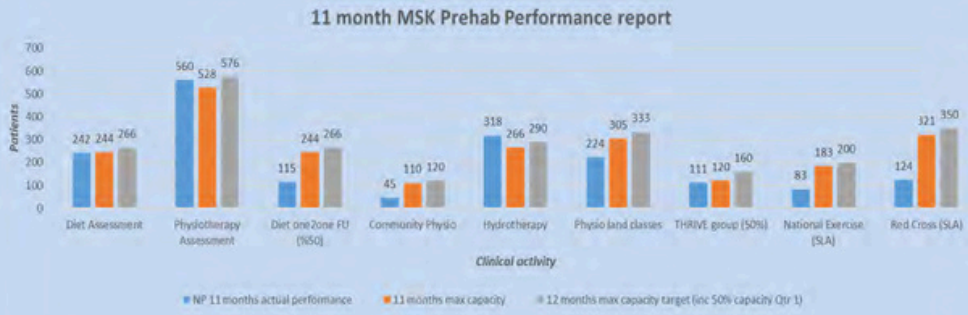


Figure 1: Ortho Prehab Service performance report.

Results

Physiotherapy:

Early data from patients who have received physiotherapy intervention show that their function and PROM scores were maintained. Alongside this, pain and analgesic use was reduced. The Ortho Prehab Service has prevented patients from requiring other primary care and Therapy services.

OHS/OKS pre	OHS/OKS post
11.8	11.5

Table 1: Improvement in Oxford Hip and Knee scores.

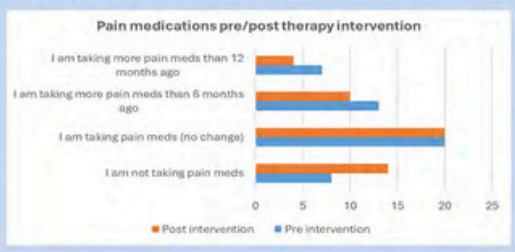


Figure 2: Improvement in pain management/ medication.

Dietetics:

SBUHB currently set a target BMI of < 40 kg/m² for patients to be able to access surgery. Over the first 12 months, 266 patients with a BMI ≥ 35 kg/m² (mean weight of 114 kg and mean BMI of 42.2 kg/m²) were offered dietetic assessment through face-to-face, telephone, or video contact.

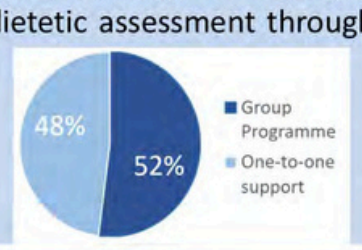


Figure 3: Figure 4. Dietetic Treatment Opt-in: Groups vs 1:1 (n=258).

The digital uptake for group sessions was 12% versus 88% face-to-face, while 24% of one-to-one patients preferred a hybrid approach (combining face-to-face and remote sessions).

Mean weight loss:	-5.7 kg
% of patients achieving BMI<40 kg/m²:	34% (n=18)

Table 2. Weight/ BMI outcomes in BMI ≥ 40 kg/m² category

Patient evaluation surveys demonstrated high satisfaction with the programme with 83% rating it as 'excellent service' and 100% stating they would recommend it to others.

Discussion

From a physiotherapy perspective patients maintained function in a cohort we would normally expect a deterioration. Through running sessions including hydrotherapy/gym classes we have reduced the load on outpatient physiotherapy services considerably. The diagram below illustrates how savings can be made across the Health Board.

Figure 4. Value in health & Ortho Prehab

On the other hand, the dietetic input in a complex cohort, similar that of Level 3 Specialist Weight Management service, shows the benefit of such a programme with many patient achieving their surgical target BMI.

Changing the focus of waiting lists from a passive process to actively engaging patients has huge potential to improve health outcomes. Patients are naturally motivated to improve their health status in line with future planned surgery. Using this time to identify patients with deteriorating health status and delivering AHP Prehabilitation supervised support can improve health outcomes and subsequently optimise surgical pathway resources by removing inefficiencies. Prehabilitation has already been shown to reduce costs in post-operative care including length of stay. Applying these principles across wider planned care pathways in Wales using a similar model could improve surgical efficiencies and outcomes.

There are three main limitations to our service evaluation. Firstly, as PROMs/PREMs are collected via an email or telephone link with an online survey we are reliant on the digital literacy of patients. Secondly, many of the outcome measures are self-reported so open to subjective interpretation. And finally, our results are reliant on attendance to clinic appointments as well as class and therapy input.

Conclusion

The Ortho Prehab Service has proven to be both feasible and valuable, with many patients maintaining their function prior to surgery and others successfully achieving their pre-surgical target weight. The success of this program highlights the potential benefits of prehabilitation services, and further studies should be conducted on a larger scale to assess its broader utility and impact on patient and service outcomes.

Next steps

Our ambition is to enable earlier patient access to Prehabilitation support by optimising the balance between capacity and demand. We also aim to expand the service to cover other specialities, including foot and ankle surgeries, as well as general surgery. As we continue to evaluate and publish our findings, our goal is to refine the service further, ensuring broader access and improved outcomes across various surgical specialties.

Exploration of the representation of the allied health professions in senior leadership positions in the UK National Health Service

Gwen L Roberts [5], Nicola Eddison [1,2], Aoife Healy [1], Nina Darke [3], Mary Jones [4], Millar Leask [2], Nachiappan Chockalingam [1]

Background

Allied health professionals (AHPs) form the third biggest workforce in NHS(1), but strategic leadership positions for AHPs within the NHS have been relatively small(2).

Investment in AHP leadership leads to improvements in patient care, resource use, collaboration and innovation(3).

This study aims to assess the current state of AHP strategic leadership within the NHS.

Method

A freedom of information request was sent to all NHS Trusts and health boards (HBs) looking at:

(1) if the Trust/HB had a Chief AHP role

(2) the job title

(3) the professional background of the post holder

(4) if the position was included on the Trust board

What We Found

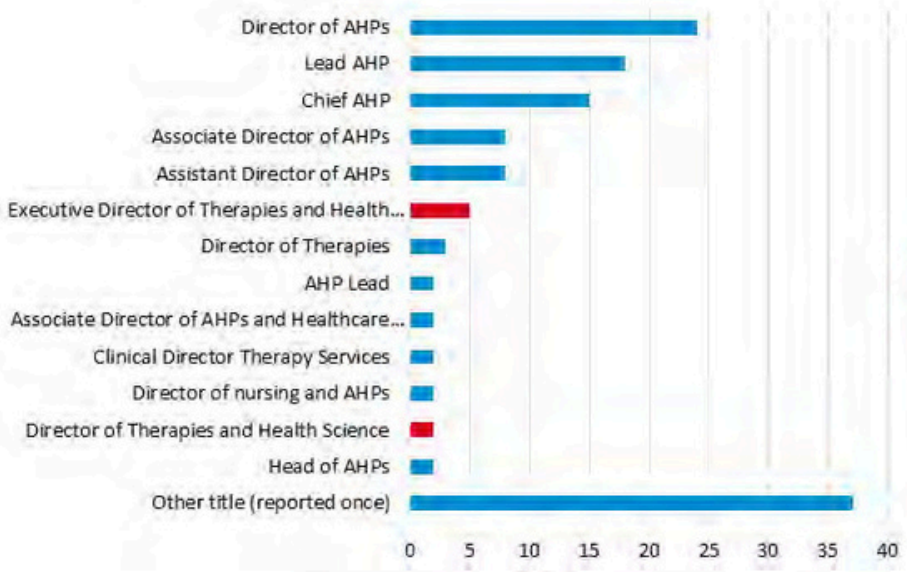


Fig. 1

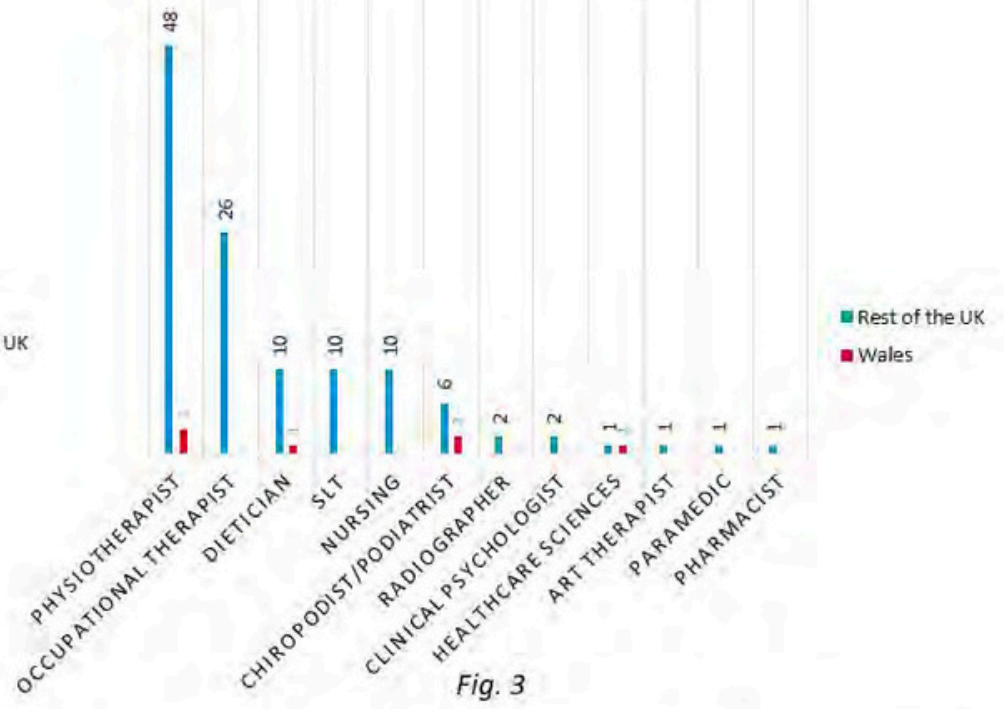


Fig. 3

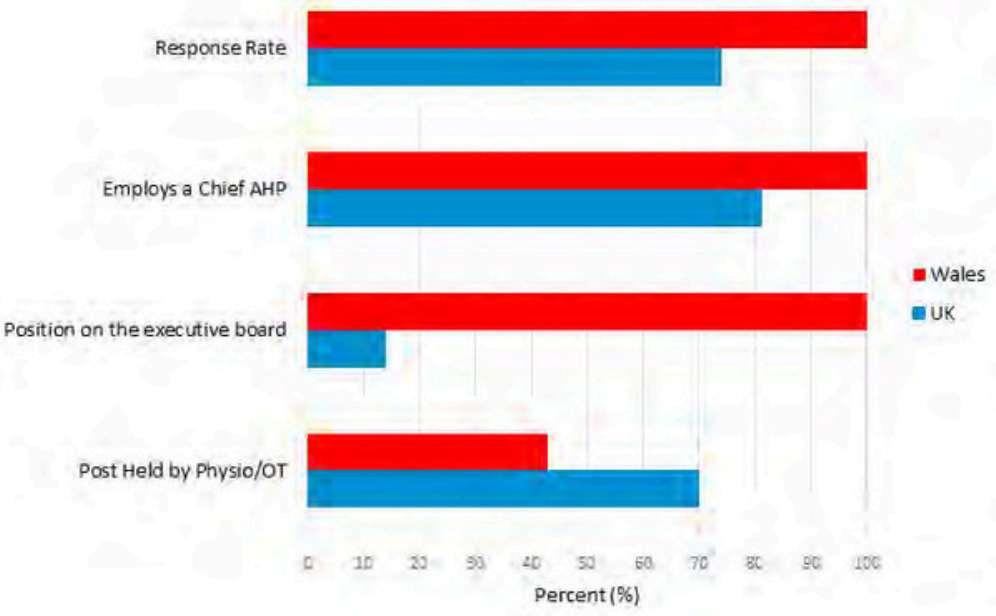


Fig. 2

- Wales has only 2 titles for this role- The Director or Executive Director of Therapies and Health Science, whereas the UK as a whole reported 50 (fig. 1)
- All HBs in Wales have a Chief AHP, as opposed to 81% across the UK (fig. 2)
- All Welsh Chief AHPs are on the executive board, as opposed to 14% of the UK as a whole (fig. 2)
- In Wales, 6 of the 7 Chief AHPs have an AHP background (fig. 3)

Application to Wales

- Wales has made some excellent steps to implement strategic AHP leadership, such as welsh policy ensuring Chief AHPs sit on the executive board
- The role title "The (Executive) Director of Therapies and Health Science" does not utilise the term "AHP" and therefore may not be readily identifiable
- Similarly to the rest of the UK, Chief AHPs come from larger professions and may not have an AHP background. Smaller AHP professions are not represented in leadership positions
- Changes in AHP strategic leadership are needed to address these inequities and improve the contribution of AHPs to healthcare.

Why is Representation Important?

In Wales, 3 HBs employ Prosthetists, however only one HB responded saying they did.

If the HB itself is unaware of their variety of employees, there will be no strategic development around supporting these smaller professions.

Acknowledgements

This project was part of the BAPO Research Hub. Findings were recently published: Eddison N, Healy A, Darke N, et al. Exploration of the representation of the allied health professions in senior leadership positions in the UK National Health Service. BMJ Leader 2024;8:119-126.

1. Centre for Biomechanics and Rehabilitation Technologies, Staffordshire University, Stoke-on-Trent, UK 2. Royal Wolverhampton NHS Trust, Wolverhampton, UK 3. Yeovil District Hospital NHS Foundation Trust, Yeovil, UK 4. Royal Berkshire Foundation Trust, Reading, UK 5. Cardiff and Vale University Health Board, Cardiff, UK

References

(1) NHS England. *Allied health professions into action*. 2017: 1–135. **(2)** Allied Health Solutions. *Allied health professions: the workforce and the services they provide. Comprehensive guide*. 2017. **(3)** Department of Health & Social Care. *Policy paper. review of health and social care leadership in England: terms of reference*. 2021

"Heart Failure Rehabilitation in ABUHB: the development of patient nutritional education and dietary support"

Authors: [1]Helena Davies, [1]Donna Price
[1]Department of Nutrition and Dietetics, Caerleon House, Newport, NP10 8BA

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Background:
Heart Failure Cardiac Rehabilitation has well reported benefits for patient outcomes including reduced mortality, delayed deterioration and reduced hospital admission (BACPR, 2023). Within Aneurin Bevan University Health Board (ABUHB), Dietetics was not directly providing specific input for heart failure patients. Butler, T et al (2020 stated education is an important element of cardiac rehabilitation.' Therefore, ABUHB Heart Failure Rehabilitation team agreed this priority needed to be addressed.

Aim:
- Develop and integrate nutritional support into the ABUHB Heart Failure Cardiac Rehabilitation Services.
- Provide dietary knowledge and support to enable patients to implement a balanced diet and reduce their risk of further cardiac events and co-morbidities.

Method:
Following a successful value-based project, delivered by a Heart Failure Nurse Led Outpatient Service, the need for dietary education became apparent (Project brief, 2022).

•Group education sessions and one-to-one nutritional support, was created based on the 'Eat Well Guide' (EWG) and the Mediterranean diet, at a user-friendly level.
•Using ABUHB population data & MDT expertise, a 4-session dietetic program was created.
•Each package-of-care delivered, offered a consistent standardised approach, reducing inappropriate variations in care.
•A guided self-management booklet provides key messages to promote patient engagement and self-empowerment to implement healthy lifestyle changes.
•A PDSA cycle has been created with value-based health care to evaluate the dietetic offer and attendance.

The programme launched in one locality at a time and is currently running in three established community hubs. The population area with the greatest percentage of secondary care admissions due to Heart Failure were targeted first (project brief, 2022). All patients identified as being suitable for rehabilitation, can opt into the dietetic programme via a clinical workstation (CWS) referral. These referrals are triaged by the dietitian to target appropriate support streams and complete assessments, making personalised care plans.

Figure1

Figure2

Discussion:
The service is designed to allow care closer to home by offering rehabilitation in multi-professional community hubs, to provide a Pan-Gwent offer. As demonstrated, service access has continuedly developed since commencement and is set to further increase with further community hubs rolling out. Utilisation of group education has allowed significant patient contact,and has a cost saving effect and improved sense of community support. Future development of virtual group education could further develop this, increasing uptake. Future analysis of the service intends to explore increasing the uptake of secondary, tertiary and further appointments.
The co-production of the Heart Failure Rehabilitation Service provides patients with access to full MDT services within one programme of care. The continued use of digital documentation enables this new service to record Patient Reported Outcome Measures (PROMS), whilst communicating more effectively about care provided. This user-friendly approach to documentation enables dietary questions & patient results to be included for all those entering and on programme.

Results:
Since the programme was established the proportion of patients entering the hub and accepting Dietetic input has progressively increased. Since the launch in May 2023, with a total of 285 patients have been referred into the bespoke arm of the service.
A total of 77.9% (n=522) booked an initial appointment . Across the service attendance rates for dietetics during the first 12-month period was good; 68% attended booked appointments (522 of 768 booked contacts).Service evaluation will look to further improve these initial starting figures.
During these contacts, a total of 613 group contacts were had, 134 telephone contacts and 20 face to face contacts.

Conclusion
Nutrition support and dietary education can successfully be fully integrated into an MDT approach to heart failure rehabilitation as evidenced within ABUHB. Further qualitative evaluation will enable the service to continue to grow and meet the needs of the population in Gwent. Currently there is no standardised dietetic approach in the secondary management, or delayed deterioration, of patients with heart failure. This project shares learning and a new approach to setting up a dietetic service, that can be used as a framework for structured dietetic education for heart failure patients in other areas

References: BACPR. (2023). The British Association for Cardiovascular Prevention and Rehabilitation. London : The British Association for Cardiovascular Prevention and Rehabilitation. Retrieved from http://www.cardiacrehabilitation.org.uk/docs/BACPR-Standards-and-Core-Components-2023.pdf.
Butler T, Kerley CP, Altieri N, Alvarez J, Green J, Hinchliffe J, Stanford D, Paterson K. Optimum nutritional strategies for cardiovascular disease prevention and rehabilitation (BACPR). Heart. 2020 May;106(10):724-731. doi: 10.1136/heartjnl-2019-315499. Epub 2020 Feb 25. PMID: 32098809; PMCID: PMC7229899.

CTM 2030 Ein Hiechyd Ein Dyfodol
DATBLYGU CYMUNEDAU IACHACH GYDA'N GILYDD

CTM 2030 Our Health Our Future
BUILDING HEALTHIER COMMUNITIES TOGETHER

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

STARTING WELL · GROWING WELL · LIVING WELL · AGEING WELL · DYING WELL

Rapid Assessment & Prevention Occupational Therapy Service

Current CTMUHB OT offers and response targets

Out patient	Primary Care Services	Reablement	Community Admission Avoidance	Front door services	Admission
Long term conditions management Routine referral response times. Current target is up to 12 weeks	Preventative interventions for chronic condition management including frailty. Route referral response times. Current target is up to two weeks.	Planned rehabilitation programmes up to 6 weeks duration for those in the community. Duty rota for those in programme in crisis.	Community based referrals for acute presentations at risk of admission Response priorities: Red - 24 hours Amber - 72 hours Green - 7 days	Patient has been conveyed / self presented at Accident & Emergecny Accident & Emergency and Same Day Emergency Care Admission Avoidance services will respond.	Patient has been admitted to a District General Site. Acute therapy teams will respond.

Aim: Establish a 4 hour urgent OT response service across community and primary care in the CTMUHB region, prioritising admission avoidance at the earliest point of crisis.

999 calls
Clinical Navigation Hub response

Benefits & Realisation KPIs

- Reduction in ambulance conveyance rates
- 85% compliance with 4 hour OT response to Navigation Hub
- 85% compliance with 24 hour (Red) OT response in the @Home service
- 85% compliance with transfer of ongoing care needs within 48 hours of OT assessment

Impact	Total
Referrals	203
Conveyances avoided	153
Cost saved	152, 541
Average % success rate	75
% compliance 4 hour response	92
% compliance red @Home 24 hour response	100
% compliance 48 hours transfer	100

Referrals where conveyances could not be avoided:

- **76% required conveyance following medical review**
- **14 % opted for WAST conveyance rather than Navigation Hub home visit**
- **10% had no identified OT needs following triage**

Impact Narrative.

A GP and OT assessment ensures a **holistic assessment to prevent future** reasons that would amount to repeated ambulance/A+E attendances (Nav Hub GP)

OT in the Nav Hub is having such an impact (Clinical Director AHPs)

Raising the profile of OT as best placed **problem solve crises** (Principal OT)

Seamless sharing of information with front door teams which is helping **support timely decisions** so a patient can return home (OT in SDEC—A&E)

OT has enabled medical intervention to **compliment and synergise** with social/functional implementations to provide the **best potential outcome** for a patient **to succeed and thrive** in the community (Nav Hub GP)

Next steps

Trusted Assessor Status:

Discussions with Local Authority partners for OTs to have direct access to commissioning packages of care to commence the same day for admission avoidance.

Transfer of care:

Utilising intervention plans for community rehabilitation services to follow to reduce the need for reassessment and commence interventions in a more timely manner

Supporting the front door:

When conveyances are necessary, developing pathways to support front door colleagues and in-patient teams to highlight strengths and barriers at the earliest opportunity to expedite discharges.

Pathways to share RAP assessments with Front door and in-patient teams to reduce duplication and support patient flow.

Extended hours and 7-day model:

Current offer is core hour service. Plans to explore extending service hours to 6pm.

Aspiration to achieve a 7-day model

Jane Paxon—Principal OT Community & Primary Care (Jane.Paxon@wales.nhs.uk)

Quality Improvement

A PREVENTATIVE APPROACH

Optimising Developmentally Supportive Positioning on the Neonatal Unit

Jen Williams, Acute Neonatal Lead Physiotherapist, lead author in collaboration with
Bethan Parsons, Specialist Neonatal and Early Years Lead Physiotherapist and
Sue Jervis, Advanced Neonatal Occupational Therapist Cardiff and Vale University Health Board

BACKGROUND

Did you know?

The All Wales Neonatal Standards highlight the key role of AHP's in the delivery of developmental care on neonatal units.

No Welsh neonatal unit currently meets neonatal workforce recommendations for AHP's.

40 – 50 % of babies born preterm will develop co morbidities, increasing to 77% for those born before 28 weeks gestation. This is a significant public health concern with preterm births accounting for 8.3% of births in Wales.

Effective developmental care reduces neonates stress, reduces length of hospital stay and improves long terms outcomes, including motor development and cognition.

Developmentally supportive positioning is a key component of developmental care. This preventative approach has been shown to reduce musculoskeletal abnormalities, aid bone density development, support neurodevelopment, support infants' self regulation, improve physiological function and stability, support skin integrity, thermoregulation and sleep. Postural stability is a foundational milestone for normal motor development. Premature infants are unable to achieve this without support that promotes, containment, flexion and alignment. Unwell term infants and those with congenital diagnosis may also require support to achieve postural stability.

Neonatal Physiotherapists and Occupational Therapists provide their own essential and highly specialist clinical skills in neonatal care for high risk neonates. We also share foundational clinical knowledge and skills which strengthen our ability to add value and influence as part of the neonatal team in the delivery of developmental care. Our influence supports an equitable, early and preventative approach, to optimise the development of all infants in neonatal care.

AIM

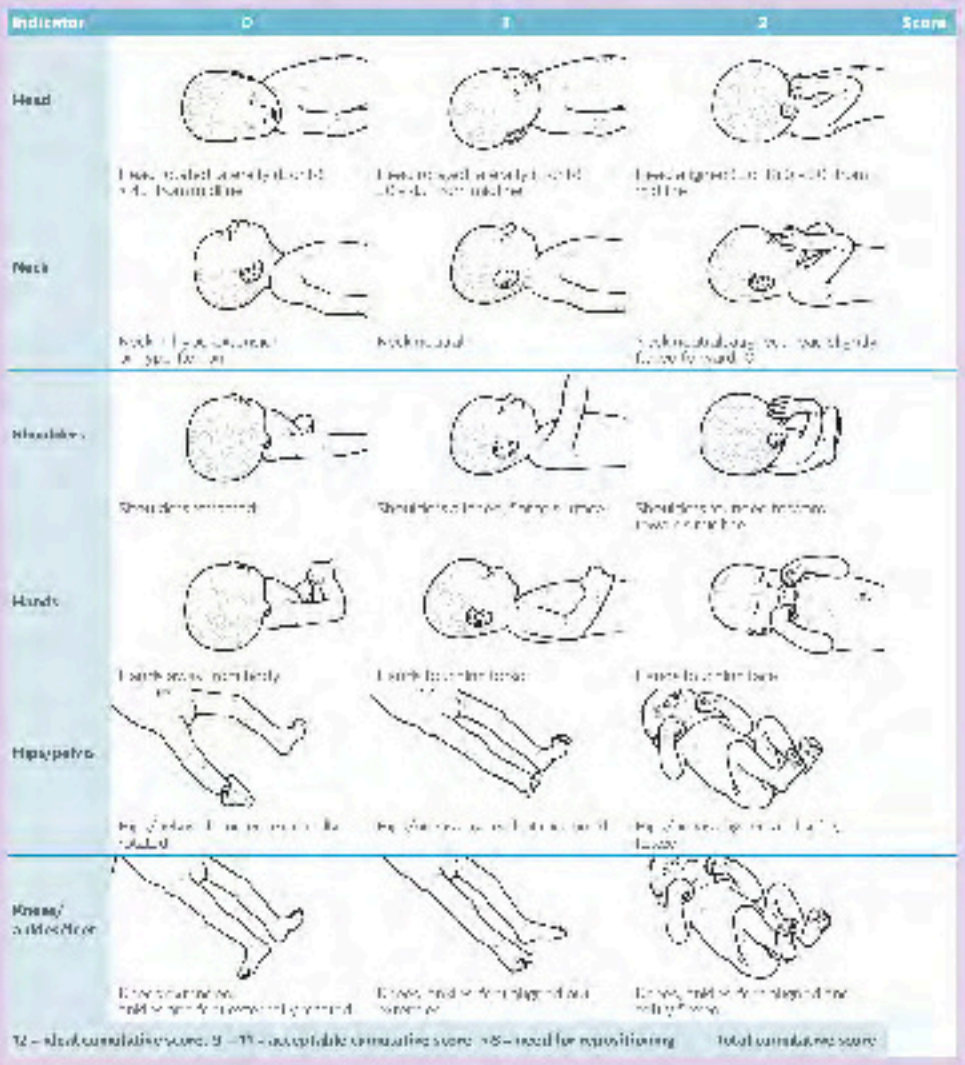
To optimise developmentally supportive positioning as part of developmental care on the neonatal unit by achieving a mean iPAT score of 9 or above across the neonatal unit.

METHOD

The Infant Positioning Assessment Tool (iPAT) is a validated tool that can be used to evaluate the positioning of neonatal infants in six areas of the body,using a 12 point scoring system.

12 = Optimal 9 – 11 = Acceptable

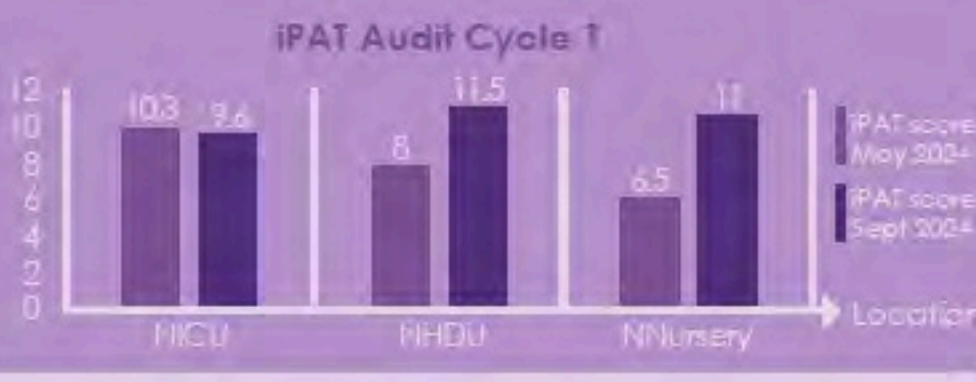
< 8 = Need for positioning support



AUDIT CYCLE ONE (MAY 2024 TO SEPTEMBER 2024)

An education strategy included:

- Formal education sessions for HDU and nursery nursing staff.
- Formal education session for medical staff.
- Informal, early and regular cot side teaching sessions on the unit for parents.
- Establishing Family Integrated Care (FiCare) rounds weekly as part of the neonatal team, providing an opportunity to collaborate with families, nursing and medical staff.
- Raising awareness of and accessibility for nursing colleagues to the All Wales Developmental Care Guidelines via UHB intranet.



RESULTS

Mean iPAT scores for May 2024 and September 2024 for Neonatal intensive care unit (NICU), Neonatal high dependency unit (NHDU) and the Neonatal Nursery (NNursery). All areas achieved a score of >9 following the education strategy in audit cycle one.

OUR NEXT STEPS

This demonstrates how AHP's leading collaboration, can improve the quality of neonatal services. Improving neonatal outcomes for all infants who receive neonatal care, has the potential to reduce the burden on specialist services later during a childs' development. Ongoing audit cycles will contine, to monitor developmentally supportive positioning, with specialist positioning equipment to be introduced and initiatives to further reduce barriers identified through parent and nursing staff questionnaires.

GROW GETTERS

Occupational Therapy

Growing together

Enhancing health and connection through nature and creativity.
A Community Neuro Rehabilitation Service group offering a holistic approach to rehabilitation through gardening, restoration, and multiple media crafts in both indoor and outdoor environments. It focuses on improving function and well-being in five key areas:

Upper limb activities

Holding tools (cylinder grip)
Sowing seeds (fine finger Dexterity, sensory input)
Painting (tripod grip)
Raking and digging (gross motor skills, shoulder stability and balance).

Cognition/Planning

Recognising and sorting what produce was suitable for eating, what may be suitable to replant and what was for composting was another example of a cognitive problem-solving task.

Problem solving skills were used throughout all sessions. One problem the group faced was watering the plants during the week when the group was not running. Together they produced the idea of watering systems and together worked out how to design and create drip feeders.

Fostering a sense of purpose

Week on week the patients get to see the benefits of their hard work, this led to a sense of shared responsibility with pride in the outcomes being achieved.

Peer support/ Teamwork

Participants were keen to help each other, recognising where their strengths could benefit others. Over the weeks as relationships grew, the confidence to offer and accept help also grew. This supported the group ethos of growing together.

Participants were keen to ensure everyone was involved and included, fostering a sense of belonging.

Patient comments

'I now have some purpose in my days as I have been attending the venue every day to look after the plants. Natalie is helping me to become a volunteer. Until joining the group I had no interest in gardening as I do not have access to a garden myself, I have really enjoyed it'.

'I enjoyed seeing other people and having a laugh with them and having a fun enjoyable time.
It was enjoyable and the past 2 months have been good and I have looked forward to coming'.

'It was very enjoyable, and I hope to continue with the other project Natalie has supported us to access.
I enjoyed all aspects. I was made to feel welcome by staff and getting to know other people in the community. It has given me confidence to meet and mix with other people'.

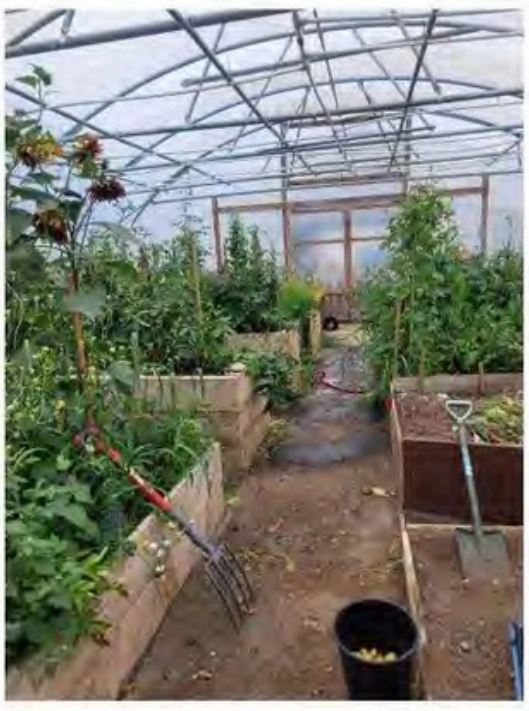
'A big thank you - I really enjoyed the sessions.
It is a friendly healthy and supportive group'.

'Thank you for all your help, coming to the group has helped me so much to find things I enjoy'.

The Grow Getters Group is an Occupationally focussed community-based initiative, designed to support patients of the Community Neuro Rehabilitation Service (CNRS) using an innovative and holistic approach to rehabilitation. The program integrates gardening and creative activities to enhance participants' physical, cognitive, emotional, and social well-being. Over six weeks, participants engage in structured activities that promote movement, sensory stimulation, emotional well-being, cognitive development, and social interaction.
The program aligns with Cardiff and Vale's Occupational Therapy strategic plan, offering targeted, evidence-based, occupationally focussed care within a community setting. It leverages partnerships with local charities and community organisations to ensure sustainability and cost-effectiveness, while also addressing potential challenges such as participant engagement, location constraints, and resource limitations.
Each session focuses on specific rehabilitation goals, with activities tailored to the individual needs of participants. The sessions have been successful in fostering a sense of community, improving physical and cognitive functions, and enhancing overall quality of life for the participants. The program has received positive feedback, with participants showing increased confidence, improved mood, and greater social engagement.

Areas of Focus

Movement: Enhancing mobility, strength, and coordination through physical activities.
Sensory: Stimulating senses through interaction with plants, crafts, and outdoor surroundings.
Emotional: Fostering enjoyment, creativity, and a sense of achievement in a supportive environment.
Cognitive: Promoting cognitive skills such as memory, concentration, and learning new skills.
Social: Encouraging interaction, communication, and connection with others in a shared purpose.
Vocation: Developing key workplace skills, fostering future-focused thinking. considering emerging opportunities, preparing for sustained success in future opportunities.



Right Care Right Time Right Place

Place based care – Based in communities away from the traditional hospital setting.
Targeted care –Towards a set group of people designed and delivered in an innovative way.
Upstreaming services – Linking patients with volunteer and community services in line with the rehab model level 1 – Keeping Me Well.
Increased accessibility – Bringing therapy to communities in which people live- the longer-term vision would be to explore an offer in a few cluster areas.

Sustainability

With support from the staff lottery the Grow Getters were able to purchase much needed equipment, including adapted hand tools- this will ensure that Grow Getters can access other less equipped venues.

Produce from the project is donated to the local Pantry, with the group giving back to the community and supporting access to fresh produce for those on lower incomes. Unused or unsuitable produce is replanted or composted for future crops.

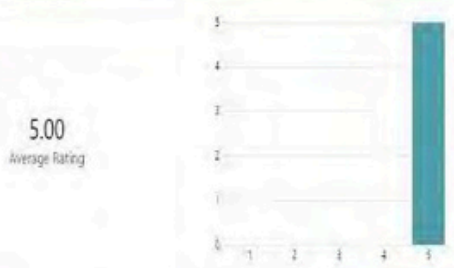
Evaluation Tools

Proms- EQ5D5L (used as a service outcome measure)
Prems- Patient satisfaction questionnaire (results below).
PDSA cycles to capture and evaluate service development and engagement.
Weekly session reflections and detailed case recordings.
Verbal feedback from patients, and referrers.

I felt valued and included as part of the group

Attending the group improved my feeling of wellbeing

My individual needs were respected and supported



Following Grow Getters I would consider attending other community opportunities.

I was supported to locate other groups and options based on my preferences

Aligning with the Cardiff And Vale OT strategy plan

Doing only what we can do
Occupationally focussed – use of meaningful activity to formulate therapy interventions, considering various methods for delivery to offer a diverse activity programme.
Strong professional identity – remaining occupationally focussed throughout the planning and delivery of the group.
Evidence based practice – using discovery/recover through activity to guide session planning.
Innovation and improvement – working in a nonclinical setting and using innovation to fund and run the sessions. Using evaluation to improve the offer as it gains traction.
High value service – working with community groups and charities to keep overall care cost down.
Partnerships and integrated working- working with 3rd sector, charities and local authority colleagues to deliver the service in a community setting. Inviting MDT colleagues to visit and support group intervention to gain different perspectives and invite colleagues to co-produce.
Diversity and inclusion – the group is intended initially for CNRS patients. The plan will be to open the offer to patients accessing the Live Well service in general to ensure equity across the service.

What next

The Grow Getters Group, an initiative within the Community Neuro Rehabilitation Service (CNRS), has demonstrated significant value and effectiveness. By incorporating therapeutic activities such as gardening, creative arts, and structured social interaction, the program addresses the diverse needs of its participants, enhancing their physical, cognitive, and emotional well-being.
The positive outcomes and feedback highlight the necessity of continuing and expanding this initiative. The success of the Grow Getters Group underscores the potential for community-based rehabilitation programs to complement traditional medical approaches, offering a holistic path to recovery.
Looking ahead, the program aims to broaden its impact by integrating with additional community services and securing the necessary resources for sustainability and growth. The Grow Getters Group serves as a model for innovative, Occupationally focussed, patient-centred care, adaptable to meet the diverse needs of various communities. Prioritising the expansion of its reach and securing additional funding will be crucial for enhancing resources serving a broader population and reducing occupational injustice.

Natalie Hughes – Highly Specialist Occupational Therapist. Email - Natalie.hughes9@wales.nhs.uk

COLLABORATIVE WORKING BETWEEN OCCUPATIONAL THERAPY AND PHYSIOTHERAPY ON A NEONATAL UNIT: A CASE STUDY.

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Lead Author – Sue Jervis, Occupational Therapist (MSc OT) in collaboration with **Jennifer Williams**, Physiotherapist (BSc PT).

Rosie

1

FAMILY

Mother, father, 3 siblings originating from Saudi Arabia currently living in UK whilst father studying. Visa expired during hospital stay and Rosie transferred back to Saudi Arabia after being with us for 7 weeks.

Older sibling described to present very similarly to Rosie at birth and went on to have multiply high level orthopaedic surgeries and diagnosed with Larson's syndrome and later autistic spectrum disorder.

COMMUNICATION WITH PARENTS

- Gathering background information, their observations of Rosie, e.g. what helps her to settle, when does she become upset etc.
- Empowering parents as primary caregivers.
- Encouraging cuddles.
- Explained and providing written advice for positioning
- Teaching passive stretches for lower limbs

2

INITIAL PRESENTATION

- Born at 39+3 weeks weighing 2.6kg.
- Significant respiratory difficulties were evident and she was therefore intubated for 10 days and then moved to NIPPV.
- Hips initially appeared fixed in a flexed position achieving no more than 90% extension, and adducted, with knees hyper-extended and mild positional talipes.
- Very easily unsettled.

WHAT WERE OUR INITIAL INTERVENTIONS?

- Seen by OT when arriving to NICU. Nest built within incubator supporting side-lying posture accommodating lower limb posture. Written advice provided to staff and parents. Advice given regarding nappy changing in side-lying. Established parents had not cuddled Rosie and wanted to.
- Minimising handling when possible, however cuddles with parents prioritised with PT advising using wrapping to calm Rosie during transfers within the incubator and when lifting out for cuddles.

3

ADDITIONAL INFORMATION DISCOVERED THROUGH ASSESSMENT AND OBSERVATIONS.

- Bilateral hip dislocations.
- Mild scoliosis.
- Gastro-oesophageal reflux (nasojejunal feeding).
- Chromosomal abnormality (GLDN gene) also present in older sibling.
- Unsettled due to handling and noise and becoming more distressed as her breathing would then become dysregulated.

CHANGES MADE TO RECOMMENDATIONS OVER TIME

- PT and OT continued reinforcement of positioning .
- Additional weighted supports added to aid with comforting.
- OT assessment highlighted reduced tolerance to noise therefore following full team discussion Rosie was relocated to a quieter space on the unit; from this time staff reported needing to give Rosie fewer sedative medications through the daytime.
- Becoming less unsettled with nappy changes.
- PT able to update positioning advice to include supine lying.
- Advice given was updated by either PT or OT.

4

NEONATAL INTENSIVE CARE UNIT, UNIVERISTY HOSPITAL FOR WALES, CARDIFF

- A Welsh regional unit provide tertiary level care for neonates requiring surgery and those referred from foetal medicine alongside support for the local population of Cardiff and the Vale of Glamorgan.
- From 2024 all AHPs became represented on the unit (0.6WTE for OT, PT, SLT & Dietetics) Whilst positive the allocation is way below national recommended standards).
- We are therefore a new team and as such are learning how our roles complement each other and cross over.
- As a unit we are invested in providing effective developmental care and family integrated care, which involves evidence-based strategies that empower parents, reduce stress for babies, reduce length of hospital stay and improve long terms outcomes, including motor skills and cognition.

WORKING AS A TEAM

- Working together we can better optimise the developmental outcomes, ensuring individual needs are identified and met.
- Whilst there is overlap in the focus of these two therapies OT and PT have distinct areas of expertise in which each profession can add its own value in individualising a baby's care which this case study demonstrates and explores.
- Liaising with the full medical team ensured that an holistic view was considered.
- A collaborative therapies approach, in partnership with her family, ensures that advice provided covers all aspects of her developmental needs.
- Our expertise and input from arrival on the neonatal unit enabled early intervention to optimise outcomes and to empower the family from the beginning of their journey. It also supports a consistent approach despite many different professionals being involved.

OT = occupational therapist **PT** = physiotherapist