

Clinical leadership for NHS commissioning

Exploring how allied health and other health professionals lead change through and beyond commissioning for a patient led NHS

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Kate Wortham

November 2007

Clinical leadership for NHS commissioning

Executive summary

1. *Clinical leadership for commissioning in the NHS* looks at how clinicians from a wide range of professions can help design and deliver service improvement for the benefit of patient care and improve health of the population.
2. The focus to date has been on GP engagement. Whilst this is vital, GP engagement on its own is insufficient if commissioning is to be truly effective. Frontline clinicians from across the professions need to be involved.
3. This document looks at commissioning in the NHS, associated leadership and networking. It provides examples of how allied health professionals and other frontline clinicians have achieved service improvements and contributed to the commissioning process.
 - a. Redesign of multi-professional services feature in 15 of the examples with seven multi-agency, usually NHS and local authority, often with voluntary sector involvement. They include social services, housing and education.
 - b. Examples were submitted by physiotherapists (15), dietitians (5), radiographers (4), podiatrists (3), speech and language therapists (3), art therapists (3), occupational therapists (2), pharmacists (2), orthoptists (1) and biomedical scientists (1).
 - c. Examples include new or redesigned services including changes in skill mix. Some are still in pilot stage. Many benefits are highlighted including - improving access to services, reducing waiting times, meeting 18 week wait target, moving care closer to home, patient choice and cost efficiency.
 - d. Service areas covered include - orthopaedics; pain management; diabetes; vision in stroke survivors; adult rehabilitation; intermediate care; pre-school and school age communication; diet and nutrition; ophthalmology; acquired brain injury; mental health; Parkinson's disease; oncology; breast screening; continence; anticoagulant monitoring; haemato oncology.
- e. Approaches cover a wide range from simple low or no cost changes to complex whole systems redesign. There is a mobile phone service for urgent access; changes in skill mix with training programmes; to delivery of service in a different location or to a different patient group; widening focus to include whole family; introducing or changing existing triage to make more effective and efficient use of resources and reduce waiting times; rescheduling screening; joining up service and providing single point of access to wide range of services across agencies.
4. Commissioning is the driving force in the NHS for the provision of high quality health services, reducing health inequalities and improving the health of the local population. PCTs are working with practice based commissioners, local organisations and a range of providers to achieve effective commissioning.
5. Commissioning involves the identification of need, securing services to meet that need, performance managing and evaluating the delivery of services. It requires knowledge, resources, action and, at times, management of change.
6. The implementation of practice based commissioning (PbC) acknowledges the need to engage frontline clinicians in commissioning both for their knowledge of patient needs and services, and also to ensure delivery of services and service changes.
7. Frontline clinicians from across the professions need to be engaged and involved if commissioning is to be truly effective in - identifying need and services to meet that need; ensuring delivery of services including changes in services; performance managing within clinical services the delivery of effective care.

8. Clinical engagement in commissioning can only be achieved if clinical leadership spans across the entire clinical workforce at operational and strategic levels. This clinical leadership must be enabled, empowered and effective to achieve the required level of clinical engagement. Clinical leadership needs to be at all levels that impact on the commissioning process and across all health professionals engaged in the delivery of frontline services. Clinical leadership is being promoted with GPs. It now needs to be promoted and enabled with other health care professionals.
9. To achieve effective clinical leadership in commissioning –
 - a. PCTs need to:
 1. Ensure strategic clinical leadership from within the professions to influence the direction of travel and draw on the diversity of talents.
 2. Ensure the Clinical/Professional Executive Committee (PEC) has a multi-professional membership and routinely involves all professions.
 3. Ensure PEC members are supported to actively and consistently engage across the professions in their work and decision making
 4. Empower frontline clinicians from the PCT's own and other provider organisations to contribute both spontaneously and in response to specific engagement activities, making best use of all available clinical resources and thereby improving financial efficiency.
 5. Work with the professions to identify local leaders from within the professions who can stimulate the collective action needed to contribute to planning and delivery of services including service changes that will result in effective patient care and improved health.
 6. Support the development of clinical leadership and clinical leaders from across the professions, so the local health community becomes a dynamic system focused on patients (and their carers), at the same time making best use of resources to achieve excellence in health care, improved health and financial balance.
 - b. Health professionals need to –
 1. Develop a better understanding of commissioning and be willing to contribute to identification of need and planning of services.
 2. Work together across professions for commissioning of services, to ensure services are patient focused rather than organisation or profession focussed.
 3. Build on the experiences of local clinical leaders from the professions and encourage those who have held (or still hold) clinical leadership roles (e.g. in PECs, service redesign, service development) to continue and develop those roles further.
 4. Develop clinical leadership by - identifying, empowering and developing clinical leaders; and, taking collective action in support of clinical leadership within their own and across professions for the delivery of patient care and health.
 - c. Department of Health and NHS need to –
 1. Promote and support multi-professional clinical leadership and engagement within PCT and PbC commissioning.
 2. Help to develop further multi-professional clinical leadership within NHS commissioning, by insisting that commissioning is multi-professional and challenging decision-making that fails to engage clinicians from across the professions.
 3. SHAs need to ensure strategic clinical leadership from within the professions at SHA level and within PCTs.
 4. SHAs need to monitor PCTs' performance on the extent and effectiveness of multi-professional engagement in commissioning, including PbC decisions.

Foreword

I am delighted to commend this paper to you since it is so timely with the advent of 'World Class Commissioning'.

Commissioning has the potential to radically transform the health and social care system, but only if it values the diversity of talents within that system both to inform the commissioning cycle, but also to provide the creative solutions for service redesign.

AHPs can offer the solutions to some of the system's most complex problems. We work both within and at the interface between the NHS and so many other parts of the system, including social care, education, housing, the voluntary and independent sector. But much of what we can offer remains 'hidden' because AHPs are often invisible in the managerial hierarchy. What is highly visible, however, is the difference

we make to a patient's outcome and as commissioning for outcomes gets more sophisticated, I anticipate our contribution will be more evident. The examples highlighted in this paper exemplify that. They also demonstrate how AHPs and other professionals can contribute to not only the most complex of problems, but also those very high on the national and local priority list – the 18 week wait, financial health, long term conditions and obesity to name but a few.

I hope this paper will be a catalyst to commissioners, whether at practice or PCT level, to engage the wider health care team in commissioning a truly transformed health and social care system.



Karen Middleton
Chief Health Professions Officer
Department of Health

November 2007

Introduction

Previous NHS Alliance documents have provided vivid examples of how allied health and other primary care professionals are redesigning services and leading change in primary care. Yet too often we hear the refrain “doctors and nurses” as if the contribution of allied and other primary care professionals did not matter. This document sets the record straight!

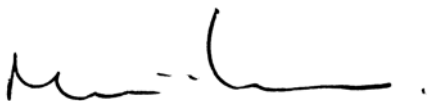
This work highlights the value of AHP and other health professionals in providing clinical leadership for commissioning in the NHS. This is illustrated with examples of numerous leading edge projects that bear witness to the expertise, energy and commitment of AHP and other health professionals in primary care.

The new emphasis on Practice Based Commissioning is about emancipating frontline clinicians and their patients to provide improved services in local health. Too often, PBC is focussed on GPs without proper recognition of the crucial role of all frontline clinicians, especially when it comes to improvements in services and health that are relevant to their own disciplines. The NHS Alliance AHP/PCP network has 26 different professional groups represented on its leadership team and it is this number and diversity of AHP/PCPs that has led to their role being under recognised.

That is now in the past as PCTs and practice based commissioners increasingly recognise

the central role of allied health professionals and other practitioners in developing imaginative local commissioning plans and providing innovative services in primary care. To achieve their full potential, health professionals will need to be involved at all levels of commissioning and, especially, with the PEC (clinical executive) of the PCT. This paper provides some important recommendations as to how AHPs and other professionals can play a more active and important role in the design of services and thus be more effective in improving them.

Proper recognition of the recommendations outlined in this report will be only half the battle won. We will also need to encourage a cultural change. One that puts allied health professionals and other practitioners at the centre of all relevant PBC planning and one where those professionals themselves feel that they are fully involved, when appropriate, in the development of local commissioning and provision. This document is a huge step towards that becoming reality. Many thanks are due to Kate Wortham, our overworking AHP/PCP network lead, who has been much of the brains and brawn behind this document.



Dr Michael Dixon

Chairman
NHS Alliance

November 2007

1. Commissioning in the NHS

***Clinical leadership for commissioning in the NHS* looks at how clinicians from a wide range of professions can help design and deliver service improvement for the benefit of patient care and the NHS.**

This document looks at the elements of commissioning, leadership and networking. Examples are given of service improvements frontline clinicians have achieved in their own service or working together with other health professionals and providers from across health, social care and other sectors. The examples are given within the main text, listed in the references and presented as vignettes in the appendices.

1.1 The Department of Health in *Health reform in England: update and commissioning framework*[1] defined commissioning as

‘the means by which we secure the best value for patients and taxpayers.....

- the best possible health outcomes, including reduced health inequalities;
- the best possible healthcare;
- within the resources made available by the taxpayer.’

1.2 Commissioning is about a cycle of activity. When considering commissioning activity Woodin (2006), says ‘Commissioning is the set of linked activities required to assess the health care needs of a population, specify the services required to meet those needs within a strategic framework, secure those services, monitor and evaluate the outcome.’[2]

1.3 The DH expands on commissioning saying ‘At the heart of commissioning there are the millions of individual decisions of patients and clinicians that lead to the provision of care and the commitment of resources. Behind these clinical decisions lies a range of separate but related processes that collectively make up commissioning, from needs assessment, through reviewing services and deciding priorities, through contracting and procurement, to seeking feedback on the services provided. Together these processes can be thought of as a commissioning cycle.’

1.4 However, as Roche (2004)[3] highlighted the lack of input from professionals into commissioning. ‘If the very people responsible for taking forward input from those delivering services don’t recognise it

as important and act on suggestions, there is little opportunity for health professionals to re-shape services in response to patient needs, let alone there being any opportunities for patients to influence decisions.’

1.5 Since 2004, there has been a recognition that clinicians need to be actively engaged in the commissioning process through practice based commissioning (PbC). This has led to the focus on the important role and influence of GPs on the use of NHS resources as the clinician providing the majority of healthcare and referring most patients to secondary care.

1.6 GPs are generalists, providing frontline care. Behind that frontline care is a complex array of care pathways, health care providers, resources and expertise. Advances in technologies, diversification and enhanced skills combined with evidence from research.

1.7 However, as Gray (2001)[4] says, ‘despite years of research, the available evidence is not best suited to the needs of healthcare decision makers.’ ‘At present, ...many healthcare decisions must be made for which there is not high-quality evidence.’ ‘The absence of high-quality evidence does not make evidence-based decision-making impossible; in this situation, what is required is the *best evidence available*, not the best evidence possible...’

1.8 Health professionals will be able to contribute to that evidence about their own area of expertise. They will also be able to combine that with their knowledge and experience of services and patients' experiences of those services. They can provide evidence for the need for change. In Bolton the AHP manager identified 55 acute hospital beds occupied by patients who could have been managed in a range of health and social care provision in the community [5]. In Manchester 'High Street testing' pilots of clinical services and point of care diagnostic blood tests for managing diabetes and cardiovascular disease are underway in 22 community pharmacies.

1.9 It is important commissioners take into account existing services, the way services are provided and the context in which those services are delivered. This knowledge will contribute to understanding the structure of services, what does and does not work, where change is needed and the impact any change will have on this and other services.

1.10 Questions for commissioners include –

- Is this care pathway complete? Does it take account of the needs of the patient e.g. for post-operative rehabilitation close to home?
- Is there an existing service which can be extended to enhance and meet identified service needs e.g. using community pharmacy to provide diabetes services to a Bangladeshi community in Camden and linking in group exercise from the pharmacy?

- How does this new service or change in care pathway impact on existing services that need to be retained e.g. will secondary care dietetic services require the same skills mix?

- Is there a professional development pathway that allows recently qualified clinicians to gain experience, whilst retaining experienced clinicians? (Physiotherapy is one example where there are insufficient junior posts for newly qualified and insufficient experienced physiotherapists in the UK to meet current demand.)

1.11 Workforce planning for future healthcare needs an inclusive approach with professional leads and commissioning leads working together to construct teams fit for future health care needs.

1.12 Commissioning is not only collecting of information about population and service needs; it is also planning new services and redesigning existing services. Ideas for these changes can come from outside the services, which then need to be tested with those who know the service to see how the changes can be implemented. Often there will be changes that those delivering the service identify.

Redesigned and new services implemented by clinicians.

Dietitians took lead roles in the obesity multidisciplinary team in Leeds finding ways to improve *services for obese patients in the community and the bariatric surgery pathway* [6]. More treatment options are now available, drugs budget for obesity treatment and waiting time have reduced and service is NICE compliant.

Orthoptists at Wrightington, Wigan and Leigh NHS Trust provide *visual and ocular assessment for stroke survivors* [7] who have a high incidence of visual impairment, and provide training for all staff with direct access to stroke patients.

Physiotherapists have redesigned services to improve access, reduce waiting times and improve services for patients. These include *orthopaedic clinical assessment service (CATS)* [8, 9]; bringing together through *a single point of referral with service redesign physiotherapy services* [10] in Kent; *orthopaedic triage* [11] a *paediatric therapy triage Service* [12] in Knowsley.

Podiatrists from Calderdale and Huddersfield redesigned the *annual foot assessment for patients with diabetes* [13] doubling number of patients screened by changing the skills mix, providing training and changing the care pathway. In Gloucestershire they set up a *podiatry orthopaedic triage service* [14] to triage e-referrals to secondary care.

Hot Foot Phone [15] is an innovative approach to service access problems for patients with diabetes designed by podiatrists in Leeds using a mobile phone.

Review of breast screening round [16] led a consultant radiographer in south east Scotland to redesign screening visits in order to turn blocks of referrals, which built up waiting times, to a more steady flow. To maintain the 3 year screening interval the new schedule will take three 3-year screening cycles to implement.

Radiographers in Cambridge have put forward a proposal for Department of Health funding to be a site for an innovative new *tomotherapy system – image guided radiotherapy service* [17] based on researched evidence of uses.

Services delivered in different settings

A multi-professional group led by head of nutrition and dietetics established a *diabetes pathway across Brent* [18] that bridges the gap between primary and secondary care, ensures patients are directed to appropriate clinician (over half are for AHPs) and improved access to services.

A team of dietitians, a nutritionist and nutrition support workers now provide paediatric dietetic services with a *family based dietetic service* [19] in children's centres in Blackburn and Darwen, tackling root causes of feeding problems such as parent cooking skills; working with local authority exercise and fitness team.

Speech and language therapists in Weston Super Mare worked with the local authority to provide two services in schools. *SALT – Speaking and listening together* [20] with speech and language therapists and trained assistants and *SALSA – Speech and language secondary age* [21].

Speech and language therapists in Bedfordshire identified hard to reach groups needing to improve communication skills. With the PCT and Children's Centre commissioners they have found a multi-agency solution, *delivering speech and language therapy through Sure Start Children's Centres* [22] providing better outcomes for children and families with savings for NHS and other services.

Community pharmacists in the North East of England are providing *pharmacy-based anticoagulant clinics* [23] increasing access for patients and reducing amount of time they need to take out to attend a hospital clinic.

Clinicians developing new and redesigning services

A physiotherapist working as business change manager across organisations and with different professional groups and services has developed a whole system redesign with single point of access, specialist teams following patients, integrated working in localities and workforce changes for *Reclaiming independence; a strategy for redesign rehabilitation services for adults in Calderdale* [24].

In Birmingham physiotherapists are developing a pathway that will allow physiotherapists who are *extended scope practitioners to list for surgery* [11] including spinal, foot, shoulder and knee as well as for epidurals.

A physiotherapist coordinates a newly commissioned *local acquired brain injury service* [25] in Hertfordshire that links across local organisations, provides care locally rather than in a regional centre, reducing costs and bed days, providing more local support. Team includes psychology and occupational therapy posts.

Art therapists in Scotland's Robert Fergusson Unit provide *services for acquired brain injury patients with challenging behaviour* [26] helping patient to address the trauma associated with their injury. In Surrey art therapists designed a *personality disorder service* [27] having identified no organised service was in place and demonstrated the effectiveness of the services with a pilot programme.

Physiotherapists in Doncaster and Bassetlaw are developing *continence clinics in primary care* [28] and are piloting a *physiotherapist practitioner based fracture clinic* [29].

A multi-professional team are developing a *pain management* [30] service in Birmingham offering a 'one-stop' approach to assessment and care planning in the community. The team will include a consultant in pain management, clinical specialist physiotherapist in pain management, consultant clinical psychologist and a GP with special interest in pain management.

Using tools for redesign

In Bolton staff from the acute trust, PCT, social services and a commissioner worked together on *redesigning stroke services in Bolton Hospitals NHS Trust using LEAN methodology* [5] to improve services, outcomes and access, and bring stroke services into line with Royal College of Physicians standards.

Physiotherapists in Knowsley find the *service demand tool (Nottingham Weighting)* [31] useful for staff reorganisation and evidence for business cases for services.

1.13 Commissioning requires both strategic decision making and operational change. Strategic leadership from across the professions is important to ensure influence from across the professions on the direction of travel and strategic decision making benefits from their diverse talents and expertise.

1.14 Commissioning new or redesigned services is about change in service delivery. There will be times when commissioning is about service change where part of a service is lost. In both these cases it is vital that there is full clinician engagement to ensure the new or remaining patient services

are delivered to the required level and standard. This requires engagement of frontline clinicians delivering the services and management of change.

1.15 Commissioning is monitoring and evaluating services to ensure they reach the required levels of activity and standards of care. It is ensuring this is managed at service delivery. It requires adequate feedback on services to inform future commissioning.

1.16 Finally, NHS commissioning, where it is about decisions on use of NHS resources, involves many decisions made daily by frontline clinicians across the professions when they make referral, diagnostic investigation and treatment

decisions. This is sometimes referred to as micro-commissioning.

- 1.17 GPs are seen as prime micro-commissioners, but there are also many other frontline clinicians from across the health professions who are making similar decisions. For example - first contact nurses, physiotherapists, orthoptists screening children, optometrists for cataracts or glaucoma, signposting by community pharmacists to other services, and so on.

- 1.18 Support for clinicians to participate in commissioning has understandably focused on GPs. There have been some events and professional support such as the Chartered Society of Physiotherapy's two guides, *Payment by Results* [32] and *Making the Business Case* [33]. Primary Care Contracting has published PbC bulletins [34] including one on multi-professional involvement, with the NHS Alliance, and one on pharmacy and PbC.

2. The case for clinical leadership

- 2.1 The case for leadership was put by the DH in *Operating framework 2006/7* [35]

'Leadership across the NHS, and particularly in the new Primary Care Trusts (PCTs), remains the key to delivering improved services to patients.'

And reiterated in the following year in *Operating framework 2007/8* [36]

'It is the very nature of the reforms that improvements must be owned and delivered by clinicians, managers and other front-line staff on the ground.....It is the responsibility of the NHS community leadership... to engage fully with clinicians, staff, patients and the wider public to communicate and explain the need for change and the potential of the reforms locally to improve services and people's lives.'

- 2.2 The case for clinical leadership is clearly stated by Lord Darzi in his *Our NHS our future: Interim report* [37], saying the DH will 'ensure that local decision-making processes are subject to greater public and clinical scrutiny including ensuring the local case for change is led by clinicians,..'. Leadership is in areas for action and clinical leadership highlighted.

'The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS and to create a consistent focus on the needs of

patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence.'

- 2.3 The need for clinical leadership has been acknowledged with the decision to implement practice based commissioning (PbC). This has led to direct involvement of many GPs in both micro-level commissioning decisions, for example for demand management, and engagement in the wider impact commissioning decisions including moving service into the community.
- 2.4 The use of the term leadership denotes a proactive and more responsible role than the terms 'engagement' or 'involvement'. However, those terms and their actions remain key as they denote the joining up of the results and effort that may be brought about by leadership.
- 2.5 The terms engagement and involvement require individual clinicians and groups of professionals to take collective action. One element that underpins effective collective action is leadership. This leadership is about individual leaders and multi-level leadership. It is about translating concepts and ideas so that they have meaning for colleagues working with patients, designing services or considering patient needs. It is about building commitments and agreement

to go forward – addressing population and service needs, changing services, delivering services.

- 2.6 This leadership engagement and involvement is required at the strategic

as well as operational levels. It is required to guide and influence strategic direction, as well as implement change.

Translating a service to a new area

The experience of Parkinson's: words and images through art therapy [38] is a pilot project funded by Goldsmith College in London to explore whether art therapy can alleviate depression and help prevent long term mental health problems developing for people with Parkinson's disease.

Tomotherapy provides image guided radiotherapy (IGRT), the radiotherapy delivery system of the future. There are currently no tomotherapy units in the UK. In response to an invitation from Department of Health, a research radiographer in Cambridge has identified uses for IGRT for the *Tomotherapy proposal* [39].

Broadening the scope of service provision

Therapists in South Tyneside obtained access monies to prevent hospital admission, which they used to appoint a technical instructor and a rapid response occupational therapist. Their *expansion of intermediate care services* [40] now covers all beds in the intermediate care unit (health and social care), provides triage and rehabilitation programmes that follow the patient into the community.

A therapy radiographer is a member of a multidisciplinary team with a nurse, dietitian and speech and language therapist providing *head and neck AHP post radiotherapy support clinic* [39] set up to meet the needs of patients in the six-week post radiotherapy period, reported by patients as the worst time.

Extended scope practitioner physiotherapists in Birmingham are developing a pathway which allow them to *list patients for orthopaedic surgery* [11] including spinal, foot, shoulder and knee surgery and epidurals.

Extending clinical skills to meet service needs

A consultant radiographic practitioner in Grimsby has developed a training protocol and is implementing *training breast ultrasonographers in interventional procedures* [41] so they can perform cyst aspirations and breast biopsies, reducing waiting times for patients and symptomatic clinic time.

Physiotherapists in Kent have developed *urogynae physiotherapy in primary care* [42] reducing referrals to secondary care and waiting times. The team are enhancing their clinical skills anticipating increased referrals to include promotion of men's health and bowel dysfunction clinics.

Leadership and power

| Type of power | Based on |
|---------------|--|
| ➤ Coercive | Fear, punishments, threats. Autocratic |
| ➤ Expert | Acknowledged expertise, skills, knowledge |
| ➤ Legitimate | Hierarchy, perceptions |
| ➤ Referent | Charismatic, admired, want to identify with person |
| ➤ Reward | Ability to provide rewards |
| ➤ Connection | Relationships with influential partners |
| ➤ Information | Access to information valuable to others |

Adapted from Hannagan T (1998) *Management Concepts & Practices*[43]

- 2.7 Leadership brings with it different contexts of power (see box), most of which will meet certain needs in relation to commissioning.
- 2.8 Expert power, that comes with acknowledged expertise, not only for those commissioning the services but in respect of other clinicians working in the same field, will be important.
- 2.9 A clinician on the PEC bringing the frontline clinician view to discussions and decision-making, will have legitimate power in his/her leadership position. However, PEC members also need to demonstrate they have taken account of all the professions involved and can demonstrate access to the right information and the right relationships.
- 2.10 There will be frontline clinicians from different professions in the leadership position with information that will be acknowledged by commissioners and peers of value to the commissioning process.
- 2.11 Frontline clinicians in management roles will also hold legitimate power, may be in a position to offer rewards, will have connections, information and expertise in their professional as well as management role. These are examples of the types of leadership powers that will be needed to inform commissioning, service development and redesign and manage change.

Taking lead roles

An occupational therapist was appointed project manager to lead the *redesign of intermediate tier of service* [44] in Calderdale bringing together fragmented services. The service was the first jointly funded by health and social care in the area. Referrals are to a single contact point using uniform criteria, assessment tools and documentation. It operates 24/7 for people 18 years and over.

Allied health professionals took lead roles in commissioning and clinical pathway redesign of *orthopaedic integrated clinical assessment and treatment service (ICATS)* [9] in Kent. A physiotherapist led implementation of redesigned hip and knee referral and management pathway. Physiotherapists led business case submission for commissioning and clinical models for management of trauma and orthopaedics, rheumatology and chronic pain referrals to secondary care.

Orthoptists have identified gap in service provision for *visual and ocular assessment of stroke survivors* [7] and are working to become a member of the stroke team included in the National Stroke Strategy to published later this year.

In Brent, a dietitian has been the elected chair of Wembley Practice Based Commissioning Cluster [45] since 2006 successfully leading a multi-professional Board that has met its performance targets and gained PCT approval of its 2007/08 Commissioning Plans.

3. Multi-professional clinical leadership

- 3.1 This paper highlights the importance of multi-professional clinical leadership in NHS commissioning. However, it is not only necessary to identify a need for multi-professional leadership, it is also essential to show how leadership and engagement can be achieved.
- 3.2 The nature of multi-professional engagement and leadership is confusing, with activity by many in different places and different times.
- 3.3 The number of health professionals and professions involved can seem challenging. But groups, such as allied health professionals and different specialties within nursing, have been facing this challenge for some time. The individual professions have their own identity; training and clinical practice will cover different areas and may at times overlap for some.

Multi-professional leadership

Many examples have been across professions including taking the project manager roles in *Calderdale reclaiming independence* [24] led by a physiotherapist and *redesigning the intermediate tier* [44] led by an occupational therapist; a physiotherapist coordinates the *local acquired injury service* [25] multi-professional team in Hertfordshire; therapy lead in South Tyneside is physiotherapist and acted across therapy professions for *expansion of intermediate care services* [40]

Therapists in Oxfordshire developed a *professional advisor for therapies* [46] job description to take account of need for leadership at a strategic level for service provision, commissioning, public health and workforce issues for physiotherapy and occupational therapy. The post has not been implemented as yet in Oxfordshire but AHPs in other areas are looking at the proposed model.

Royal Pharmaceutical Society has developed with the NHS Institute for Innovation and Improvement an *inspiring leadership: leading across boundaries* [47] programme for pharmacists. This is seen as multi-professional involving pharmacists as well as pharmacy specific developments.

There was a multi-professional approach to *establishment of a diabetes pathway* [18] in Brent. The Wembley PBC Cluster Board is multi-professional with 3 GPs, a dietitian (chair), a pharmacist and an optometrist [45].

So how can this be managed without having representation from every professional group?

Networks

- 3.4 Networks are one way forward. In the SDO Networks Briefing (2004) [48] enclave networks are highlighted as useful for sharing information and ideas among

professionals. These networks have a flat internal with no central authority and are based on shared commitment. There is a place for the formal hierarchical networks, with structure and authority; and also for individualistic networks where there are loose associations of affiliates that may be services, organisations or even an individual.

Working together and networks

West Hertfordshire neurological rehabilitation service team had strong local networks including adult care services, voluntary sector and 'work solutions' assisting people back to work, when *commissioning a local acquired brain injury service* [25]

Developing a business case and *implementation of haemato-oncology diagnostic service in North Trent region* [49] was a multi-professional exercise, bringing together biomedical and clinical scientists from different disciplines and institutions, clinical haematologists, histopathologists, cancer network facilitators and business planning team. This brings together haematology, histopathology, cyto and molecular genetics with integrated report.

In Doncaster and Bassetlaw *multi-professional development of clinical pathways* [50] for orthopaedics brings together consultants, GPs, managers from the Trust and PCT and orthopaedic physiotherapists, saving time dealing with any barriers to the pathway. Development of referral pro-forma is multi-professional. There is good joint working between the acute Trust and PCT.

Redesign of *ophthalmology pathway* [51] business case was written jointly by dietitian board chair of Wembley Practice Based Commissioning Cluster and optometrist board member in Brent.

Joint working *redesigning stroke services in Bolton* [5] means stroke patients are directly admitted to a stroke rehabilitation unit from A&E; an early supported discharge team and community in-reach team will reduce lengths of stay and improve patient outcomes; access to OT and physiotherapy will be within 1 working day; assessment duplications will be avoided; communications will be improved including a relatives clinic.

Joint working to *redesign rehabilitation services in Manchester* [52] has led to development by PCT and social services of home based health and social care rehabilitation service, sheltered housing, expansion of community intermediate care beds; and, reduction in hospital based rehabilitation services. Resulting in fewer delayed discharges; greater range of services available to patients; access to home rehabilitation.

Stakeholder events

- 3.5 Stakeholder events are a way of bringing together different health professionals, ensuring everyone is up to date with progress and plans, as well as engaging across the profession on issues and ways forward. Stakeholder events have

been used by PCTs and practice based commissioning consortia. In Hampshire the local pharmaceutical committee held an event with the local medical committee, PCT commissioners and directors of nursing to map out patient pathways for long term conditions. Stakeholder events were used in

Calderdale as part of an eight month programme of engagement for *reclaiming independence: strategy for redesigning rehabilitation services* [24], which included interviews, presentations and focus groups.

Taking on representation for one another

- 3.6 One health professional taking on representation for colleagues from

different professional backgrounds is a challenge, which has been very successful in some areas. The traditional partners for representation among the allied health professionals (AHPs) are physiotherapists and occupational therapists. There are also many examples of excellent multi-professional representation from across AHP professionals on PCT Professional Executive Committees.

4. Conclusions and areas for action

- 4.1 There is great potential and energy within the NHS family and the frontline clinicians who deliver, plan and organise services for patients and their carers. At times the split between provider and commissioner can feel threatening and divisive. Practice based commissioning has emphasised the pivotal role of GPs in NHS healthcare and their gatekeeper role.
- 4.2 However, not all health care is accessed through the GP entrance. The diverse nature of healthcare needs, provision and development, means no one person can encompass all aspects of care.
- 4.3 The discussion and examples presented in this document demonstrate the can do approach, the value of multi-professional involvement in planning and commissioning of health care and implementation of service changes.
- 4.4 This requires clinical engagement and clinical leadership from across the professions at both the operational and strategic levels.
- 4.5 To achieve effective clinical leadership in commissioning –

PCTs need to:

- a. Ensure strategic clinical leadership from within the professions to influence the

direction of travel and draw on the diversity of talents.

- b. Ensure the Clinical/Professional Executive Committee (PEC) has a multi-professional membership
- c. Ensure PEC members are supported to actively and consistently engage across the professions in their work and decision making
- d. Empower frontline clinicians from the PCT's own and other provider organisations to contribute both spontaneously and in response to specific engagement activities
- e. Work with the professions to identify local leaders from within the professions who can stimulate the collective action needed to contribute to the planning and delivery of services including service changes that will result in effective patient care and improved health.
- f. Support the development of clinical leadership and clinical leaders from across the professions, so the local health community becomes a dynamic system focused on patients (and their carers), at the same time making best use of resources to achieve excellence in health care, improved health and financial balance.

Health professionals need to:

- a. Develop a better understanding of commissioning and be willing to

contribute to identification of need and planning of services.

- b. Work together across professions for commissioning of services, to ensure services are patient focused rather than organisation or profession focussed.
- c. Build on the experiences of local clinical leaders from the professions and encourage those who have held (or still hold) clinical leadership roles (e.g. in PECs, service redesign, service development) to continue and develop those roles further.
- d. Develop clinical leadership by - identifying, empowering and developing clinical leaders; and, taking collective action in support of clinical leadership within their own and across professions for the delivery of patient care and health.

Department of Health and NHS need to:

- a. Promote and support multi-professional clinical leadership and engagement within PCT and PbC commissioning.
- b. Help to develop further multi-professional clinical leadership within NHS commissioning by insisting that commissioning is multi-professional and challenging decision making that fails to engage clinicians from across the professions.
- c. SHAs need to ensure strategic clinical leadership from within the professions at SHA level and within PCTs.
- d. SHAs need to monitor PCTs' performance on the extent and effectiveness of multi-professional engagement in commissioning, including PbC decisions.

4.6 The benefits of such actions will be maximising the use of existing resources, making best use of those resources, service improvements for patients and their carers, better health outcomes and an enabled and motivated workforce.

References

1. Department of Health, *Health Reform in England: update and commissioning framework*. 2006, Department of Health,.
2. Woodin, J., *Health care commissioning and contracting*, in *Healthcare Management*, K. Walshe and J. Smith, Editors. 2006, Open University Press.
3. Roche, D., *PCTs: An unfinished agenda*. 2004, London: IPPR.
4. Gray, J., *Evidence-based healthcare: How to make health policy and management decisions*. Second ed. 2001, Edinburgh: Churchill Livingstone.
5. Kate McKenna, *Redesigning stroke services in Bolton using LEAN methodology*. Multi-professional, multi-agency, Bolton Hospitals NHS Trust.
6. Mary O'Kane, *Obesity and Bariatric Surgery Pathway*. Dietetics, Leeds Teaching Hospitals NHS Trust.
7. Sonia MacDiarmid, *Visual and Ocular Assessment of Stroke Survivors*. Orthoptics, Wrightington, Wigan and Leigh NHS Trust.
8. Suzanne Bolam and Amanda Espey, *Orthopaedic Clinical Assessment and Treatment Services (CATS)*. Physiotherapy, Doncaster & Bassetlaw Hospitals NHS Foundation Trust and Doncaster PCT.
9. Hilary Birrell, *Orthopaedics Integrated Clinical Assessment and Treatment Service (ICATS)*. Multi-professional, Eastern & Coastal Kent PCT.
10. Pramood Selkar, *Single Point of Physiotherapy Referrals and Service Redesign*. Physiotherapy: Eastern & Coastal Kent PCT.
11. Stephanie Griffiths, *Orthopaedic Triage*. Physiotherapy, Birmingham East and North PCT.
12. Eleanor Marsh, *Paediatric Therapy Triage Service*. Physiotherapy, Knowsley PCT.
13. Debby Wolfe, *Redesigning Annual Foot Assessment Service for People with Diabetes*. Podiatry, Calderdale and Huddersfield NHS Foundation Trust.
14. Chris Boden, *Podiatry Orthopaedic Triage*. Podiatry, West Gloucestershire PCT.
15. Thomas Dickie, *Hot Foot Phone: Service for People with Diabetes*. Podiatry, Leeds Teaching Hospitals NHS Trust.
16. Janet Clarke, *Breast Screening Service Redesign*. Radiography, South East Scotland Breast Screening Centre, Western General Edinburgh.
17. Katharine Walker, *Proposal for Tomotherapy - Image Guided Radiotherapy Service*. Radiography, Cambridge University Hospitals NHS Foundation Trust.
18. Farhat Hamid, *Establishment of a Diabetes Pathway across Brent*. Multi-professional, Brent Teaching Primary Care Trust.
19. Tracey Parkington, *A New Family Based Dietetic Service*. Dietetics, East Lancashire Hospitals NHS Trust & Blackburn with Darwen PCT.
20. Gillian Oxley, *SALT - Speaking and Listening Together*. Speech & Language Therapy, Weston Area Health NHS Trust.
21. Gillian Oxley, *SALSA - Speech and Language Secondary Age*. Speech & Language Therapy, Weston Health NHS Trust.
22. Jill Snell, *Delivering Speech & Language Therapy through Sure Start Childrens' Centres*. Speech & Language Therapy, Bedfordshire PCT.
23. Noel Dixon and J. Hall, *Pharmacy-based Anticoagulant Clinic*. Pharmacy, Dixon and Hall Ltd.
24. Chris White, *Reclaiming Independence: a Strategy for Redesigning Rehabilitation Services for Adults in Calderdale*. Multi-professional and multi-agency, Calderdale PCT.
25. Sally Pollitt and Janet Lewis, *Commissioning a Local Acquired Brain Injury Service*. Multi-professional and multi-agency, Hertfordshire PCTs.
26. Lynda Girvan, *Art Therapy Service for People with Challenging Behaviour with Acquired Brain Injury*. Art Therapy, The Robert Fergusson Unit.
27. Neil Springham, *Designing a personality disorder service*. Art Therapy, Surrey and Borders NHS Trust.

28. Amanda Espey, *Continence Clinics*. Physiotherapists, Doncaster & Bassetlaw NHS Hospitals Foundation Trust and Doncaster PCT.
29. Amanda Espey, *Physiotherapy Fracture Clinic Pilot*. Physiotherapy, Doncaster & Bassetlaw Hospitals NHS Foundation Trust.
30. Eve Jenner, *Pain Management Programme Pilot*. Multi-disciplinary, Birmingham East and North PCT.
31. Eleanor Marsh, *Service Demand Tool (Nottingham Weighting)*. Physiotherapy, Knowsley PCT.
32. Chartered Society of Physiotherapy, *Payment by Results - the new funding system for the the NHS: practical support for Allied Health Professionals*. 2005, Chartered Society of Physiotherapy: London.
33. Chartered Society of Physiotherapy, *Making the Business Case: a physiotherapist's guide to commissioning*. 2007, Chartered Society of Physiotherapy: London.
34. Primary Care Contracting, *PBC Bulletins*. 2005-06, <http://www.primarycarecontracting.nhs.uk>.
35. Department of Health, *NHS in England: the operating framework for 2006/7*. 2006, Department of Health.
36. Department of Health, *The NHS in England: the operating framework for 2007/08*. 2006, Department of Health.
37. Department of Health, *Our NHS our future: NHS next stage review interim report*. 2007, Department of Health.
38. Diane Waller, *The Experience of Parkinson's: Words and Images through Art Therapy Pilot*. Art Therapy, PACE Goldsmiths College, London.
39. Katharine Walker, *Head and Neck AHP Post Radiotherapy Support Clinical*. Multi-professional, Cambridge University Hospitals NHS Foundation Trust.
40. Jon Quine, *Expansion of intermediate care services from 15 to 30 beds and beyond!* Multi-professional - therapy, South Tyneside NHS Foundation Trust.
41. Sarah Lawson, *Training Breast Ultrasonographers in Interventional Procedures*. Radiography, North Lincolnshire and Goole NHS Trust.
42. Trish Williams, *Urogynae Physiotherapy in Primary Care*. Physiotherapy: Eastern and Coastal Kent PCT.
43. Hannagan, T., *Management Concepts and Practices*. Second ed. 1998, London: Financial Times Management. 58.
44. Anita Hirst, *Redesign of Intermediate Tier of Service in Calderdale*. Multi-professional and multi-agency, Calderdale PCT.
45. Farhat Hamid, *Leadership within Primary Care*. Multi-professional, Brent Teaching Primary Care Trust.
46. Suzanne Jones, *Professional Advisor for Therapies*. Multi-professional - therapy, Oxfordshire PCT.
47. Anne Adams, *Inspiring Leadership: Leading Across Boundaries Programme*. Pharmacy, Royal Pharmaceutical Society of Great Britain and NHS Institute for Innovation and Improvement.
48. Howarth, A., *Networks Briefing: key lessons for network management in health care*. 2004, SDO.
49. Neil Porter, *Implementation of Haemato Oncology Service in North Trent Region*. Biomedical Science, Sheffield Teaching Hospitals NHS Trust.
50. Suzanne Bolam and Amanda Espey, *Multi-professional Development of Clinical Pathways*. Multi-professional, primary-secondary, Doncaster & Bassetlaw Hospitals NHS Foundation Trust.
51. Farhat Hamid, *Redesign of the Ophthalmology Pathway across Brent*. Multi-professional, Brent Teaching Primary Care Trust.
52. Elizabeth Birchall, *Re-design of rehabilitation services in central Manchester*. Multi-professional, multi-agency, Central Manchester and Manchester Childrens University Hospitals.

Examples of clinical leadership

1. Redesigning stroke services in Bolton Hospitals NHS Trust using LEAN Methodology
2. Obesity and bariatric surgery pathway
3. Visual and Ocular assessment of Stroke survivors – Role of the Orthoptist
4. Orthopaedic Clinical Assessment and Treatment Services (CATS)
5. Integrated Clinical Assessment and Treatment Service - ICATS
6. Development of single point of referrals along with service redesign
7. Orthopaedic Triage
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9. Redesigning Annual Foot Assessment Service for People with Diabetes
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15. New Family Based Dietetic Service
16. Speaking and Listening Together (SALT)
17. Speech and Language Secondary Age (SALSA)
18. Delivering Speech & Language Therapy through Sure Start Children's Centres
19. Pharmacy-based Anticoagulant Clinic
20. Reclaiming Independence; a strategy for redesigning rehabilitation services for adults in Calderdale
21. Commissioning a local Acquired Brain Injury Service
22. Art Therapy Service for clients with acquired brain injury and challenging behaviour.
23. Designing a personality disorder service.
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28. Pilot project - The Experience of Parkinson's: Words and Images through Art Therapy
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30. Expansion of intermediate care services; from 15 to 30 beds and beyond!
31. Training Breast Ultrasonographers in interventional procedures
32. Development of Urogynaecology Physiotherapy within primary care
33. Redesign of the intermediate tier of service in Calderdale
34. Leadership Within Primary Care
35. Professional Advisor for Therapies - Physiotherapy and Occupational Therapy
36. Inspiring leadership: Leading Across Boundaries programme
37. Implementation of a Haemato Oncology Diagnostic Service in North Trent Region
38. Multi-professional Development of Clinical Pathways
39. Redesign of the Ophthalmology Pathway across Brent
40. Re-design of rehabilitation services in central Manchester

1. Redesigning stroke services in Bolton Hospitals NHS Trust using LEAN Methodology

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Trust is undertaking a series of service redesign using LEAN methodology. The stroke team held a series of planning events to map out existing pathway and redesign it reducing “waste” in the process and placing the patient at centre of planning.

First event in January 2007, which lasted a week, involved mapping the Value stream, starting with 999 phone call and finishing with discharge from community neurology service, involving staff from acute Trust, PCT, Social services, and a commissioner. Team included Divisional manager, nurses, therapists, social worker, consultants, pharmacist, and radiologist and a service redesign team facilitator. 4 subsequent events have built on the initial mapping event. Assessment of current state showed changes were required and it was not meeting Royal College of Physicians standards.

The outcome of the process is an agreed pathway across the health care economy. There is redesign of services in acute hospital to provide acute stroke unit with direct admission from A& E. Redesign of current stroke rehab service to 22 bedded stroke rehab ward. Commissioners requested business plans by the 9th of July 2007 for Early supported discharge team and community rehab in reach team. Contracts to be agreed September 2007.

There are better patient outcomes with access to OT and physiotherapy assessment within 1 working day; 100% of patients treated by a specialist stroke team; aim to reduce length of stay by 8 days; use of Goal Attainment Scale by PCT and Acute Trust to avoid duplication of assessments; a relatives clinic to improve communication; better communication, use of space and assets

2. Obesity and bariatric surgery pathway

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NICE clinical guidance 43 on Obesity states that bariatric surgery is a treatment option in the management of morbid obesity. Leeds Teaching Hospitals NHS Trust (LTH) found the demand for

surgery exceeded capacity resulting in unacceptable waiting lists. The medical obesity service was similarly oversubscribed.

A working group, Obesity Multidisciplinary Team (MDT) was set up with LTH’s surgical manager, obesity surgeons, obesity physician and obesity dietitian (Mary O’Kane - MO) , NW Leeds PCT obesity dietitian/project leader (Emma Croft - EC) and PCT commissioner. The chair was initially surgical manager but it was handed to MO. EC developed the community service with a number of multifaceted treatment options and a specialist clinic for morbidly obese patients. She ensures anti-obesity medication is used appropriately and effectively, reducing costs to the drugs budget. The clinic provides the gateway into LHT service. A referral pro forma was jointly devised and contains information which can be assessed against NICE criteria.

Within LTH, medical and surgical obesity services work collaboratively. MO led development of LTH pathway to ensure 18 week target is met with: 1) a triage with patient seen initially by dietitian, presenting case to MDT (surgeon, physician and dietitians) which recommends surgical route, medical route or return to GP 2) surgical assessment 3) surgery. Obesity surgical clinics were reorganized so both dietitian and a consultant are present. Standard procedures for nutritional monitoring are followed by all. Patients following the medical pathway, have a medical clinic appointment.

3. Visual and Ocular assessment of Stroke survivors – Role of the Orthoptist

Mrs Sonia MacDiarmid, Deputy Head Orthoptist Wrightington, Wigan and Leigh NHS Trust and National SIG Lead for Stroke of the British and Irish Orthoptic Society

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This service was set up 6 years ago due to overwhelming evidence of high incidence of visual impairment following stroke. There was no input into stroke services from eye care services.

All staff irrespective of grade or profession who has direct access to stroke patients is given training on a Stroke education course on the importance of vision, visual dysfunction following stroke and what are the signs and symptoms of visual complications. There is a referral pathway where patients with suspected visual complications are fast tracked to Orthoptist for assessment.

Patients are diagnosed, treated (if possible) and advised on their condition. Patients are referred directly to a Consultant Ophthalmologist if needed. The stroke interdisciplinary team is advised on the

patient's visual limits and their rehabilitation programme is adapted to suit their individual needs. If required, patients are referred to sensory support team to aid independence and to the low vision service. The family and/or carers are contacted with the information to ensure they were fully aware of any visual problem and how to best deal with it.

Now patients are assessed during their acute or rehabilitation stay for any visual impairment, which prevents misinterpretation of tests, misdiagnosis and increases patients' rehabilitation potential.

Orthoptic profession is working very hard to become a recognized member of the stroke team. We hope to be included the National Stroke Strategy published later this year.

4. Orthopaedic Clinical Assessment and Treatment Services (CATS)

Mrs Suzanne Bolam, Head of Physiotherapy, Doncaster & Bassetlaw Hospitals NHS Foundation Trust Email: suzanne.bolam@dbh.nhs.uk Telephone: 01302 381 303

As part of service redesign to meet the 18 week wait target in orthopaedics, all orthopaedic referrals directed through Choose and Book to Orthopaedic Clinical Assessment and Treatment Services (CATS) administration team in primary care

Orthopaedic Physiotherapy Practitioners (OPPs) triage referrals on a daily basis, identify those they can manage themselves (estimated as 65% of referrals) and identify those which require an appointment for consultant opinion

The administration team offer CHOICE of secondary care organisation to patients and make appointment through Choose and Book.

5. Integrated Clinical Assessment and Treatment Service - ICATS

Mrs Hilary Birrell, Physiotherapist and Therapy Manager, Eastern and Coastal Kent PCT Email address: hilary.birrell@ekentmht.nhs.uk Telephone: 01304 865426

Orthopaedic, rheumatology and chronic pain referrals to secondary care in East Kent had a high referral rate, long waiting lists and low conversion to surgery.

Planning, evaluation of demand, clinical and non clinical implications, impact on existing services, development of new pathways and development of governance structures involved people across both PCT and acute trust, including AHPs, orthopaedic surgeons, rheumatologists, GPs, chronic pain clinicians, service managers, service users, commissioners audit and finance personnel.

Over a two year period clinical pathways were redesigned, with AHP service managers and specialist AHP clinicians taking lead roles in both commissioning and redesign processes.

Implementation of redesigned hip and knee referral and management pathway was lead by PCT physiotherapy service manager and commissioner from each locality with a phased role out, followed by the back pain pathway.

Working with commissioners, physiotherapy managers submitted a success business plan in 2007 to allow complete implementation of commissioning and clinical models for management of trauma and orthopaedics, rheumatology and chronic pain referrals to secondary care.

The outcome of innovative redesign ICATS has:

1. Given rapid access to a local, timely, more appropriate, primary care service - referrals paper triaged within 2 working days, patients offered appoint within 10 working days at a locally.
2. Reduced referral rate into secondary care.
3. Demonstrated excellent patient feedback through service user feedback audit
4. Demonstrated cost effectiveness – ICATS appointment costs are 40 – 50% of tariff.
5. Supported PCT clinicians to develop extended roles in highly specialized clinical areas.
6. Given potential for further development i.e. use of model in other clinical specialties and direct surgical listing from ICATS assessment
7. Realized further significant savings within PCT

6. Development of single point of referrals along with service redesign

Mr Pramod Selkar, Superintendent Physiotherapist, Eastern & Coastal Kent PCT- Shepway locality Email: Pramod.Selkar@shepwaypct.nhs.uk Telephone: 01303-852714/854414

Background - Physiotherapy waiting time was about 28 weeks with services two different locations and referrals were often duplicated. Patients were dissatisfied and some were forced to go to private physiotherapist, incurring a financial burden and difficulty coping with their condition.

In consultation with commissioners and acute trust development of a single point of referrals and a PCT service redesign were proposed. Single point of access was developed in collaboration with the acute trust and was implemented in November 2005.

PCT invested in increased capacity of physiotherapy services to meet demands of the local population. Telephone rather than postal appointments were implemented. Currently the service is co-hosted by PCT at acute trust location

and outreach clinics have been developed at GP surgeries providing a choice of locations.

Patient satisfaction survey was carried out by PCT.

- 75% strongly agreed that they were treated with respect and dignity during their visit
- 73% strongly agreed that they had a thorough assessment
- 57% strongly agreed that their expectations were delivered by the physiotherapist

A significant reduction in waiting times and maintained to 5 days for urgent referrals with 33% saying they waited less than 1 week, 35% waited less than 2 weeks. DNA rate dropped from 17.3% in Jan-Mar 2006 to 7.1% in Jan-Mar 2007

Referrals rate minimized significantly which is thought to be due to reduction in chronicity as patients are seen sooner.

7. Orthopaedic Triage

Stephanie Griffiths, Consultant Physiotherapist, Birmingham East & North PCT

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BEN PCT has had an orthopaedic triage service in place for last 3.5 years. Access to primary care musculoskeletal expertise has been developed by providing extended scope physiotherapy and podiatry services. Clinicians are also trained and mentored by orthopaedic consultants to ensure high correlation in orthopaedic decision making. Injection therapy can be accessed in primary care.

Access to pain management and rheumatology is being developed as well as consideration of direct access so patients will be able to attend clinics without going through their GP.

A pathway is being developed to allow Extended Scope Practitioners to list for surgery for certain specialties such as spinal surgery, foot surgery, shoulder surgery and knee surgery as well as for other procedures such as epidurals.

Outcomes include - achieving 18 week pathway; improved patient access with respect to faster and more local access; reduced waiting times for orthopaedic appointments

8. Paediatric Therapy Triage Service

Mrs Eleanor Marsh, Physiotherapist and Clinical Lead Paediatric Therapist, Knowsley PCT

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To avoid waiting lists a system has been set up where patients are signposted to relevant clinics

for assessment, i.e. Developmental Coordination Disorder clinic, Gait clinic, Acute clinic (CTEV, Torticollis, CBPL) or Triage clinic. This way all children referred to the Paediatric Therapy Service are seen within 13 weeks (DCD), 6 weeks (Triage), 4 weeks (Gait) and 2 weeks (Acute).

New appointment system has been set up where patients are asked to contact to arrange an appointment. Patients have a choice of venues.

Outcome - There are currently no waiting lists and children are seen within current waiting times. Inappropriate/inadequate referrals are dealt with without needing an appointment preventing wasted journeys by patients. Patients seen as locally as possible. Fewer DNA's.

9. Redesigning Annual Foot Assessment Service for People with Diabetes

Miss Debbie Wolfe, Podiatrist and Assistant Therapy Services Coordinator for Mobility Services, Calderdale and Huddersfield NHS Foundation Trust

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NICE guidelines require all patients with diabetes receive an annual foot assessment from which a risk rating is given for the possibility of developing foot ulceration. Funding for the service was for 1.0 wte band 6 podiatrist, which allowed 3,500 patients to receive the annual screening. However in the local population there are over 7,000 people with diabetes. The PCT was unable to provide extra funding, so the diabetes team redesigned the annual screening service, using the band 6 funding, when the post becoming vacant, to replace with 2.0 wte band 3 podiatry assistants.

Podiatry diabetes team produced a new structure and pathway for delivery of the service. This included an assistants training manual and development of competencies for training to ensure tasks were delegated appropriately and assistants had competencies to carry out screening.

Pathway proposal was presented to PEC, with PCT's support. Since December 2006 podiatry assistants undertake annual screening with capacity to meet needs of total diabetic population.

Outcome - Role redesign has led to efficient use of funding to meet capacity needs of population requiring an annual diabetic foot screen. All current population can be offered an appointment to attend for an annual screen so reducing waiting times and a better use of resources.

10. Podiatry Orthopaedic Triage

Chris Boden, Head of Gloucestershire Podiatry Services, West Gloucestershire PCT

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A Podiatry Orthopaedic Triage Service has been set up in Gloucestershire (West Gloucestershire PCT). This involves an Extended Scope Practitioner Musculo-skeletal Podiatrist triaging e-referrals into secondary care and diverting those patients with foot problems she can manage non-invasively to her primary care clinic. Those patient who require an invasive procedure are referred to our podiatric surgeon working out of a community hospital.

11. Hot Foot Phone: Service for People with Diabetes

Mr Tom Dickie, Podiatrist, Leeds Teaching Hospitals NHS Trust

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A mobile phone line open during office hours dedicated to diabetes patients and referrers, so instant access is effectively delivered, was initiated in April 2007. The proposal was to save time, money, admissions and lower extremity amputations (LEA) as well as to reduce anxiety felt by those who are already unwell and struggling to contact the hospital's diabetic foot team.

This innovation is part of continuing service improvement recommended by the team at their quarterly team meetings and follows government national guidelines (NSF/NICE) for diabetes services. Complaints about access raised this problem to a top priority.

Current local diabetic foot care pathways are agreed and on-line for referrers (GP, DN, PN, TVN etc). This direct line helps ensure relevant information is given at right time by appropriate individual. Podiatrist is able to assess needs, give advice and to see patient within 24-hours if necessary. If seen, Podiatrist is able to diagnose infection, swab, prescribe x-rays/ultrasound, wound bed management and has access to on call doctors if necessary. Patients have a choice as different hospitals can be used.

12. Breast Screening Service Redesign

Mrs Janet Clarke, Consultant Radiographer, South East Scotland Breast Screening Centre/Western General Edinburgh

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Way screening is scheduled in SESBSU means that each regional symptomatic unit is inundated

with referrals one year out of every three years with screen-detected cancers. This has a huge impact on the symptomatic services in these areas.

The screening management team managed to reroute SESBSP three-year cycle so that there are three defined areas. Breast screening will have a permanent presence in each of these areas, spreading the impact of screen-detected cancers in each region over the 3-year period

Traditionally the area has been screened by moving through it on a 3 year cycle with 3 mobile units. Proposed solution it to split the screening area into three natural occurring geographical areas all with comparable population sizes. One mobile can have a continued presence in each area, spreading screening of relevant population over 3 years in each area.

The change will be over 3 cycles and completed by the end of 2014 so accommodate fact that: screening intervals cannot be more than a maximum of three years four months; screening in two areas is due to be completed in 2007 and 2008 respectively.

Perceived benefits include

- More even distribution of screening, evening out demand on symptomatic services.
- Easier access for women, with a continued presence, which may improve health awareness and uptake rates.
- Reduced travelling time for staff.
- Extended working hours may be a possibility.
- Improved recruitment as travelling commitment for staff is reduced

13. Proposal for Tomotherapy - Image Guided Radiotherapy Service

Mrs Katharine Walker, Head of Radiotherapy, Addenbrookes Hospital, CUH

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There are currently no Tomotherapy units in the UK. A Tomotherapy system - Image Guided Radiotherapy (IGRT) Unit delivers radiotherapy in a manner similar to the operation of a CT scanner. i.e. in spiral slices. IGRT is fast becoming the radiotherapy delivery system of the future. It will also provide Intensity Modulated Radiotherapy (IMRT) – one of the most complex treatment regimes.

Oncology Centre sought approval to bid to Department of Health to be one of the 2 sites for a Tomotherapy installation, requesting support for the ongoing revenue consequences based upon full staffing model. The evaluation project will look at ease of implementation, staffing levels from a radiographer and physics prospective and efficiency of the service provided.

The business plan identified new patient groups to be treated, in addition to the change in treatment regime for the current patient groups. A research

radiographer identified possible uses of the new technology, and worked with the management team, clinician and physicists to produce a business plan accepted by the Trust and PCT, in addition to the initial paper to DH.

Outcome - Unit is to be installed in August 2007 and outcomes to be evaluated over a 3 year project life.

14. Establishment of a Diabetes Pathway across Brent

Mrs Farhat Hamid, Head of Nutrition & Dietetic Service, Brent Teaching Primary Care Trust

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In response to national move of diabetes services from secondary to primary care, Brent tPCT has led the way in London with the design of an innovative Integrated Diabetes Care Pathway. During its inception and early implementation, this pathway was led by Head of Nutrition & Dietetics at Brent tPCT. As an Allied Health Professional Head of Service, she was able to bring together various disparate stakeholders and establish a working group which she chaired on a weekly basis. This working group included a new Community Diabetes Consultant, Diabetes Specialist Dietitians, Head of Podiatry, Diabetes Specialist Nurses, a local GP with an interest in Diabetes and a representative from Ophthalmology.

The model introduced from early 2006 was an intermediate care service. Bridging the gap between secondary and primary care, a Long Term Conditions centre receives all newly diagnosed and urgent diabetes referrals from Brent GPs and triages them to appropriate community-based health professional. This ensures patients receive timely appointments, easily accessible and with a specialist in diabetes care.

Outcome - Two years after Diabetes Pathway launch, it is recognised as a successful template for other PCT pathways (both in Brent and nationally). AHPs continue to play a leading role in both delivery and future development of the pathway. For example, Specialist Diabetes Dietitians have recently launched a diabetes specific weight management programme in conjunction with Physical Activity Instructors employed by Brent Council.

Of the total referrals being sent to the Long Term Conditions office, over half are for the AHP groups (eg Dietitians, Podiatrists). The average number of referrals to the Diabetes Pathway currently stands at 147 new referrals per month

15. New Family Based Dietetic Service

Mrs Tracey Parkington, Community Dietetic Team Manager, East Lancashire Hospitals NHSTrust/ Blackburn with Darwen PCT

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Past: Dietetic clinics were unevenly distributed and waiting times varied greatly. Children were mainly seen in hospital outpatients regardless of need. A different way of working in families' homes was piloted, focusing on parenting skills not only on the nutrition problem, which was often a symptom of a more complex cause. Funding was secured for a community-wide service..

Present: A team has been recruited of Band 5 early years dietitians, a nutritionist and nutrition support workers. Paediatric dietetic clinic was moved from hospital into children's centres. New referral pathway means only most complex cases reach these specialist clinics, non-complex feeding/ nutrition problems are seen in the home by early years dietitians.

For example: a tube fed child was seen in hospital by a feeding team including specialist dietitian, speech therapist and consultant with aim of removing tube and introducing normal diet without success. Root problem was parents had insufficient cooking skills to provide foods child could manage. A nutrition support worker went to home with recipes, took mum shopping, looked at suitable foods and cooked dishes for child, provided support with refusal and praise was given. Cost of service is far less and it is much more effective.

Overweight children were previously seen in hospital clinics, putting problem just with child not with whole family, it stigmatized the child and was not very successful. As part of a new joint obesity pathway for adults and children dietetic dept is working with exercise and fitness team at Blackburn with Darwen council to provide a joint service. Groups are being set up specific to child's age to include cooking sessions, practical support and exercise. Children are also seen with their family.

Outcomes - Cost effective use of staff with the most specialist staff seeing only people who need specialist care; reduced waiting times to specialist clinics; less recurrence of nutritional problems; holistic care; services delivered more locally; home intervention can be as intense as needed; more practical help and support to families and less advice giving.

16. Speaking and Listening Together (SALT)

Mrs Gillian Oxley, Head of Speech and Language Therapy, Weston Area Health NHS Trust

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There were insufficient therapists to deliver therapy to school age children and there was a shared understanding that in most cases, children's communication needs are also educational needs and have a direct impact on their ability to access curriculum and to develop social and emotional skills

It was agreed delivery of some childrens' speech and language therapy could be delivered by suitable trained assistants rather than fully qualified Speech and Language Therapists, providing they were trained and closely supported. This leaves SLTs to see children for assessment, therapy and planning who need skills of qualified SLTs.

Service - Trained Speech & Language Therapy (SLT) assistants deliver speech and language therapy in schools, funded by Local Authority. LA funds 0.4 whole time equivalent SLT to train assistants, organize rotations, set targets for children for episodes of care and record therapy outcomes. SLT is employed by NHS Trust. LA funds and employs 4 wte assistants to deliver therapy in schools on an intensive, block basis, usually 2-3 times a week for 10-12 weeks. Other teaching assistants can be trained along side SLT assistants and also teaching assistants in schools can observe and learn from watching SLT assistants work with children.

Client group – children in mainstream infant and primary schools with speech, language and communication difficulties on SLT caseloads.

Outcomes include - improved speech and language skills and consequent effect on improved access to national curriculum, better social skills and self esteem; some children discharged from SLT caseload; transfer of skills to support children with communication difficulties to teaching staff; effective cross agency working; good use of resources by changing skill mix; therapy delivered in child's own environment; potential to reduce Out of County placements; reduction in complaints from parents & teachers about lack of SLT; high satisfaction ratings from staff and parents

17. Speech and Language Secondary Age (SALSA)

Mrs Gillian Oxley, Head of Speech and Language Therapy, Weston Area Health NHS Trust

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There was no health funded Speech and Language Therapy provision for secondary age children. Local authority and the SLT dept were aware of need for SLT skills in secondary schools. Some children are educated out of county, at great expense because the LA cannot meet their SLT needs in local schools. Case law firmly states that if SLT is in the Statement of Special Educational Need, it is an educational provision. In addition there is a wealth of evidence about link between poor communication skills and disaffection with school, low self esteem, poor social skills and youth offending.

Service – An advanced Speech and Language Therapist delivers a range of interventions to students and staff in 10 secondary schools in North Somerset, funded by the Local Authority. It funds 0.4 term-time only SLT, employed by NHS Trust. SLT visits schools on a rotation basis, offering a menu of interventions according to student needs. The menu includes: individual assessments of students, advice/programme planning for individual education plans, in service training for staff, setting up social use of language groups for staff to carry on when SLT finishes the rotation, advice and support for curriculum differentiation. The programme promotes transfer of skills to teachers and teaching assistants in addition to support for individual students

The programme is supported by a management team (Head SLT, Lead SLT, Principal Educational Psychologist). Management teams for SALT (above) & SALSA will combine in September 2007.

Client group – young people in mainstream secondary schools with specific speech, language communication difficulties at key stage 3. Programme is too small to support key stage 4, stammerers or students with a primary behaviour or moderate learning difficulty.

Outcomes are the same as with Speaking and Listening Together (SALT) delivered to children in mainstream infant and primary schools.

18. Delivering Speech & Language Therapy through Sure Start Children's Centres

Mrs Jill Snell, Speech and Language Therapy Manager, Bedfordshire PCT

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Bedfordshire PCT S< service and Children's Centres commissioners have worked together since December 2005 to improve access to S< for hard to reach groups as part of integrated, multi agency working. The focus of work is to improve communication skills of children within the population of 5 Children's Centres. This includes facilitating access for parents/carers and children to speech and language therapy support, advice and activities that promote positive parent/child interaction and communication. Therapist works as part of Children's

Centres team so a whole centre approach to communication is established. Talking Together information resource has been launched both in Children's Centres environments and in Health. Further input is planned to take forward Early Talk programme which is being promoted by charity I CAN, DfES and DoH

Outcomes - Investment in early years (0-5) in prevention and early intervention can lead to better outcomes for children and families and to substantial savings to the NHS and other public services by avoiding need for specific interventions or reducing intensity of any intervention required.

19. Pharmacy-based Anticoagulant Clinic

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A pharmacy-based anticoagulant clinic (blood-testing, supply and associated support) has been running in the North East of England for many years.

Before the clinic, all patients had to travel to the general hospital. This severely inconvenienced patients who often spent half a day on what is now a 10-minute appointment. Audits have shown that therapeutic control in the pharmacist-led service is at least as good as that previously provided by the hospital.

20. Reclaiming Independence; a strategy for redesigning rehabilitation services for adults in Calderdale

Mrs Chris White, Physiotherapist and Business Change Manager (rehabilitation), Calderdale PCT

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A range of providers and lack of focused development of services has led to overlap and gaps in service provision. A whole system review and recommendations was agreed.

A physiotherapist by background, I am seconded (since October 2006) to PCT from Calderdale and Huddersfield NHS Foundation Trust (CHFT) and have now completed review of rehabilitation across Calderdale PCT, Calderdale Social Services, CHFT and Housing. Direction of travel and implementation plan document is being presented to Boards of organisations for formal agreement.

There has been 8 months of engagement with clinical staff, patients, carers and other stakeholder using a range of methods such as presentations, focus groups, individual interviews and a stakeholder event held at the end of March 2007.

A matrix of perceptions of services was built up from service users and carers, staff at frontline, team leader, manager and strategic positions in organisations to map what works well, overlaps and gaps. Views were supported by service data.

Whole system redesign includes single point of access, stratification of need with specialist teams following patients, review of criteria to close gaps, integrated working in localities and workforce changes to ensure skill mix and capacity.

Intended outcomes - improved access times and patient experience; reduce time wasted by referrers and assessing against criteria (patients not accepted for specific services), reassessing; changes to services to close gaps; patients as close to home as possible (in right place to meet their needs) with specialist services following them; re-investment of savings in dedicated psychology service; specialist medical cover through rehabilitation pathway (promoting safe step-down from acute site); specialist stroke extended scope therapy/coordinator/matron hybrid role.

21. Commissioning a local Acquired Brain Injury Service

Mrs Sally Pollitt, Physiotherapist and Clinical Lead Neurological Rehabilitation Service and Mrs Janet Lewis, Physiotherapist and Head of Specialist Adult Services, Hertfordshire PCTs

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Patients with acquired brain injury with cognitive, behavioral but minimal physical problems were referred to a regional unit. Waiting list for assessment was long and treatment as an inpatient or outpatient was long. Once patients were admitted they stayed in a bed for a prolonged period and reintegration back to their community did not include local services.

West Herts Neurological Rehabilitation Service was already seeing a number of the patients, could see them more quickly and locally. The team had strong local networks with adult care services, voluntary sector and 'Work Solutions'(team assisting people back into work or to continue in work).

Following discussions with specialist commissioning a model was developed for a local service to decrease bed days at the regional unit, offer treatment locally and improve local support for patients during reintegration into the community. The service started on June 1st 2007 with a team comprising of physiotherapist who acts as coordinator, a psychology post and an occupational therapy post and administrative support.

Expected outcomes are a better value service for commissioners with bed days in the regional unit reduced by two thirds and a large financial saving. A

local service for most patients throughout their treatment and those needing a stay at the regional unit brought back as soon as practicable. Paper screening of patients on waiting list for regional unit suggests all suitable for local service.

A clearer pathway will be used for this client group. Gate keeping of regional beds through Neurological Rehabilitation Service with all referrals coming through the single point of access. Patients will access services within two weeks as standard once we have finished the initial tranche of assessments. Patients can be treated locally in a neurological rehabilitation bed, an outpatient base or in their home allowing one team to see them throughout.

22. Art Therapy Service for clients with acquired brain injury and challenging behaviour.

Lynda Girvan, Art Psychotherapist, The Robert Fergusson Unit

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An Art Therapy Service at the Robert Fergusson Unit for Clients with Acquired Brain Injury and Challenging Behaviour in 1999. It is staffed by an art psychotherapist two days a week. The Unit assesses difficulties and structures behavioral programmes for each client, working closely with allied health professions and nursing staff. Art therapy offers patients a choice to work in another psychodynamic way. Its role is to give clients a means of working through their feelings, allowing them to see there are alternative means of managing affect. Therapy also offers clients an opportunity to explore their creativity, helping individuals reframe experiences and consider other ways of attending to and moving on from complex and confusing inner experiences. Patients come for an assessment period of twelve weeks. The therapist's role is to assess patients' ability to use this approach. Work is one on one and in open and closed groups.

The effects of ABI can be catastrophic. Confusion and trauma are often accompanied with feelings of anger and frustration. There are the physical problems as well as cognitive impairment, making adjustment and developing resilience can be a slow and difficult journey. Where there is difficulty with verbal communication, non-verbal aspect of art therapy offer another bridge to understanding. Neutral territory is identified and patients channel feelings through activity of sculpting or painting in the presence of the therapist. In time patients can identify personal narratives and work through feelings associated with ABI and/or pre-morbid mental health difficulties.

Outcome - What tends to emerge is difficulties around "blocks to creativity". These blocks are

often about pre-morbid difficulties, feelings of bypassed shame or guilt, low self esteem and working through feelings associated with very real losses. Art therapy helps the patient to address trauma associated with their injury by offering time to order affect, to develop confidence around their creative engagement generally. Resilience is facilitated as is important aspect of developing ownership of their experiences during sessions and in the larger context.

A care pathway document has been designed to help organize records and store data.

23. Designing a personality disorder service.

Mr Neil Springham, Head of Arts Therapies, Surrey & Borders NHS Trust

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Art therapists in North West Surrey had a long history of working with patients with a personality disorder. However many patients required multi-disciplinary input but no such teams were in place. Consequently many complex need patients with a personality disorder diagnosis were contained on inpatient wards or through emergency systems, which were costly and highly ineffectual in treating the condition.

Having identified the need, art therapists were central in surveying Trust wide patient population in mental health, demonstrating whilst 50% of all patients being seen had a personality disorder, no organised service was in place. They worked actively across professional disciplines with psychology and psychotherapy. The PCT had stated that this would come from exiting resources

Having gathered evidence of best practice and worked through the NIMHE guidance, a pilot personality disorder programme was shaped up where an art psychotherapy group was delivered alongside individual psychotherapy. Outcome measures used showed effectiveness and a permanent service was implemented. Alongside this, art therapists worked in partnership with psychology and psychotherapy to form a personality disorder consultations service offering expert opinion on complex cases in mental health, creating coherent pathways and effective use of existing skills across all disciplines. These initiatives can now be present back to the PCTs as exemplars of effective practice for this large and demanding population of service users.

Outcome - This troubled group now have a designated service reducing risk and improving clinical outcome. This is anticipated to have beneficial effects on costly and ineffective inpatient treatment and A&E services and creates a pathway away from uni-disciplinary outpatient waiting lists.

24. Continence clinics

Amanda Espey, Deputy Head of Physiotherapy, Doncaster & Bassetlaw Hospitals NHS Foundation Trust and Doncaster PCT

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Physiotherapists with specialist skills in management of continence problems deliver clinics in primary care. Service was developed with continence advisory team, which has identified a number of patients, who currently are referred to secondary care, but could be managed by physiotherapy.

Referrals will be directed through continence team initially, with plan to open up access to GPs. (Main issue will be limited resources initially, whilst proving effectiveness and efficiency of service) It is recognised there is huge unmet need, so starting off bite sized service, which will be comprehensively evaluated.

As well as delivering 2 clinics per week, time has been protected to deliver training to continence advisors and district nurses. This should have a bigger impact on patients, who have less complex problems and may prevent them becoming chronic.

As service develops, it is proposed to roll out this training to health visitors and practice nurses to target women in 18-45 age group with ongoing problems post-natally. Ideally it will eventually become a routine part of well woman clinic assessment to identify problems early within this sensitive area.

Physiotherapist also delivers clinics alongside consultants in secondary care and so is aware of their practice, which patients they would want to see and which patients they would refer for conservative management prior to proceeding to surgery. Once this pathway is established, patients referred to secondary care should have already had physiotherapy and will be only be those who require a consultant opinion.

25. Physiotherapy Fracture Clinic Pilot

Amanda Espey, Deputy Head of Physiotherapy, Doncaster & Bassetlaw Hospitals NHS Foundation Trust and Doncaster PCT

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This service in very early stages of development – currently a pilot. Physiotherapist with specialist skills in management of routine fractures and soft tissue injuries will deliver clinics alongside consultants.

Currently patients may or may not be referred on from A&E. If they do get to a fracture clinic, they

often see a number of doctors of differing grades and experience in managing acute injuries. Often they get different diagnoses each time they attend and are not always managed as proactively as they could be. This can result in unnecessary follow-up visits or patients being under treated

Plan is to develop a more streamlined pathway for patients from A&E, ensuring quick access for patients who should receive physiotherapy advice and /or follow-up. Service is being developed in conjunction with consultants

Intended outcomes - Aim is to provide better continuity for patients, reduce likelihood of re-injury, reduce need to go back to GP, reduce new patient to follow up ratio

Patients who require a consultant opinion and perhaps surgery, should be picked up more quickly and have better clinical outcomes. Ideally it will link to orthopaedic pathways being developed by orthopaedic CATS teams and physiotherapy teams. Service should free up consultant time to manage more complex cases and hence speed up orthopaedic 18 week pathways.

26. Pain Management Programme Pilot

Mrs Eve Jenner, Physiotherapist Clinical Specialist in Pain Management and Operational Manager Pain Management, Birmingham East and North PCT

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Audit of established BEN PCT Orthopaedic Triage Service covering a population of 460,000 patients and 84 GP Practices identified that a high percentage of patients referred with lower back pain required a chronic pain management approach. These patients are high users of secondary care with complex pathways and a high number of consultant to consultant referrals. Audit of patients referred to acute hospital pain clinic identified that 48% had previously been unnecessarily referred to other specialities. Patients experienced waits averaging 87 weeks to consultant assessment and many waited again for psychology or physiotherapy assessment or treatment and for up to two years to access a multi-disciplinary pain management programme.

A team was formed with a consultant in pain management (clinical lead), clinical specialist physiotherapist in pain management from PCT (project lead), consultant clinical psychologist from secondary care and a GP with specialist interest in pain management, supported by a project facilitator and clerical support. It streamlined the pathway with a 'one-stop' approach to assessment and care planning. This allowed patients to see all team members in one visit at a community clinic close to home, to agree individual care plans and receive advice/treatment.

Following assessment patients may be referred to primary care services for investigation (MRI, X-ray, blood tests) or following review by the pain consultant in the multi-disciplinary pain clinic and (subject to patient choice) be listed for the appropriate intervention (e.g. facet joint injection) without a hospital appointment. This provides a seamless and streamlined patient pathway replaces current complex and long patient journey.

Outcome - New model of care was successfully piloted from September 06 – March 07 using referrals from GPs in two localities receiving 211 referrals, paper triaged in 3 working days and average waiting time to be seen of 28 working days. 153 new patients were seen with 75% of them seen in the community. Patient survey showed high satisfaction rates.

Approximately 70% of patients with low back pain of > 6/52 previously referred to consultants in secondary care can be successfully managed through the new primary care multidisciplinary pain clinic and primary care services, including physiotherapy.

27. Service Demand Tool (Nottingham Weighting)

Mrs Eleanor Marsh, Physiotherapist and Clinical Lead Paediatric Therapist, Knowsley PCT

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The Nottingham Weighting Service Demand Tool identifies within a service numbers of caseload, hours at each base, type of child and level of input required. This determines areas which need to be addressed and takes into account all grades of staff.

If this is compared with previous years findings and it indicates how staffing levels can be reorganised. Alongside this it can be used to analyse the statistics collected on a monthly basis which can be used these to put forward cases for new funding.

Outcome - Changes in staffing levels can be estimated. Helps make better use of resources and justification for decrease/increase staffing levels. It provides evidence for bids/proposals. All staff are involved and informed in the process.

28. Pilot project - The Experience of Parkinson's: Words and Images through Art Therapy

Professor Diane Waller, Professor of Art Psychotherapy, PACE Goldsmiths College, London

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Art therapy is an intervention that enables patients to address psychological and emotional issues. The project aims is to see if patients with Parkinson's Disease could benefit from exploring their experience of their condition using art therapy. It developed from positive findings from a project offering art therapy to older people with dementia. It is funded by Goldsmiths College Research capability fund, has been running for 2 years with referrals from consultants, Parkinson's Disease Society, and clinical nurse specialist. 9 patients have participated. It is planned to extend research.

Most people come with no or little experience of art making, but with a desire to address the impact of disease. Feedback from patients includes: feeling more relaxed after art therapy, experiencing less tension and tremor (during and after sessions); for some physical activity of art making appears to be beneficial; self-esteem may be improved through developing or using skills, which have lain dormant for years. Experience of physical competency and ability to concentration appear to have possible benefits. Some have found art therapy sessions provide an opportunity to communicate with a professional about emotional frustrations and difficulties of coping.

Outcome - Patients brought issues about how difficult it is to let others know about depression they are experiencing; art therapy has been where they felt comfortable to share these feelings. Some wanted an informed but "neutral" professional to relate to and help them make sense of the impact of the disease and treatment. They benefited from thinking about psychological impact of disease as separate from its physiological impact. Some are keen to keep as many skills going as possible and see benefit of art as a diversionary activity, with opportunities for concentration and a sense of accomplishment (even if they don't believe they are skilled artists).

Potential savings and better use of resources may include: help to alleviate depression; preventing long term mental health problems developing, by providing people with a way of managing the psychological impact; enabling people to become more confident at asking for support with psychological issues; positive impact on carer of emotional well being of patients.

29. Head & Neck AHP Post Radiotherapy Support Clinic

Mrs Katharine Walker, Head of Radiotherapy, Addenbrookes Hospital, CUH

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Acute toxic effects are worst in the final weeks of radiotherapy and chemoradiation schedules for head and neck cancers treatment and 4-6 week period after treatment completes.

Post radiotherapy support clinic was set up in June 2004 based on anecdotal, audit and focus group feedback, suggesting the 4-6 week gap after treatment cessation before first follow up with medical staff is too long without review. Patients reported "six week period after radiotherapy was worst time, people mentioned depression, and that it would have been helpful to have seen someone during that time". All head and neck patients are offered a multi-disciplinary appointment to see a site specific therapy radiographer and nurse, dietitian and speech & language therapist.

Outcome - Clinic was retrospectively audited in 2006 to evaluate efficiency of the clinic's service delivery and patient satisfaction. It concluded the support clinic is a valuable patient service, with 90% (52/58) of patients finding the clinic very useful. 91.4% (53/58) patients reported they felt the appointment was worth while attending. 96.9% (56/58) felt they knew who to contact about problems between this and follow up appointment. 98% (61/62) of patients reported they found the clinic supportive, and 86% (51/59) of patients found the post treatment phase easier to manage as a result of the appointment. The service is to be further explored by a prospective audit to evaluate the reduction in IP admission due to early intervention and referral.

30. Expansion of intermediate care services; from 15 to 30 beds and beyond!

Mr Jon Quine, Physiotherapist and Therapy Lead, Community Therapy Team South Tyneside, South Tyneside NHS Foundation Trust

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South Tyneside Intermediate Care Service is an excellent example of partnership working across statutory agencies (Foundation Trust, PCT, Social Services) and voluntary sector (Age Concern). Within 30-bedded residential unit (Perth Green House) Community Therapy Team (Occupational Therapists and Physiotherapists) delivered a service to 15 rehabilitation beds. The other beds were 'interim social care'. Admissions to rehabilitation beds were determined by processes outside therapist's control. Many older people were

not appropriate for physical/functional rehab and patients admitted to interim care beds with no therapy provision were sometimes clearly in need of therapy assessment and intervention.

With funding for prevention of hospital admission, the Community Therapy Team appointed two technical instructors and a rapid response OT. This enabled the team to provide a service to all 30 beds based upon need rather than bed allocation, a triage process is now controlled by therapists. Rehabilitation programs follow the older person through residential unit into the community in a way that was not possible before ancillary staff joined the team. Rehab programs work beyond the point of satisfactory risk management, and into the breadth of rehabilitation that therapists are able to offer, resulting in meaningful outcomes for the older person.

The addition of the rapid response OT into the nursing team has broadened the skill-mix of the service. Therapists can now be the initial point of contact to prevent a hospital admission (i.e. within A+E and community from GP contacts) rather than relying on a nursing assessment.

Outcome: Services are based on need rather than allocation of bed space. Rehabilitation follows older person through the service. Meaningful rehabilitation is based on potential that is not constrained by time or location. Skill mix and inter-professional working. Therapists at initial point of contact to prevent unnecessary hospital admissions. Therapists challenging existing culture and practice and advocating for the need for more community therapy.

31. Training Breast Ultrasonographers in interventional procedures

Mrs Sarah Lawson, Consultant Radiographic Practitioner, North Lincolnshire and Goole NHS Trust
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Delays were occurring in the breast symptomatic clinic when the consultant radiographic practitioner or member of symptomatic team was required to perform interventional procedures. The consultant radiographer practitioner proposed that a senior breast ultrasonographer could be trained to undertake certain procedures.

A training protocol has been developed by the consultant radiographic practitioner, which includes in-house and MSc modules in interventional procedures and clinical governance. This was passed by the trust's clinical governance meeting. The ultrasonographer has been added to the patient group directive for lignocaine.

Outcome: The ultrasonographer has progressed and has a better quality of job satisfaction. Resources are better utilized as the ultrasonographer is almost at the stage of performing cyst aspirations and breast

biopsies “solo”. This saves considerable symptomatic clinic time allowing clinical staff to give a better service to patients. The patient is not kept waiting for procedures and anxiety levels seem to have been reduced. The ultrasonographer is able to give a full explanation of the procedure involved and gains informed consent and patient trust, ensuring a professional approach to complex and possibly worrisome procedures

32. Development of Urogynae Physiotherapy within primary care

Mrs Trish Williams, Superintendent Physiotherapist, Eastern and Coastal Kent PCT

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Development of urogynae physiotherapy to provide an integrated cohesive service to reduce number of referrals into and waiting times in secondary care and provide a more efficient urogynae service across whole health economy. Services in primary care ensure patients have improved access to local services to ensure timely and appropriate interventions. The urogynae team has been treating patients for 4 years. A specialist service started 18 months ago and is now being rolled out across East Kent. The present service offers assessment and treatment for a range of conditions including stress incontinence, mixed incontinence, prolapse and symphysis pubis dysfunction. The team continue to enhance their clinical skills in anticipation of increased referrals from across the PCT, to include promotion of men’s health and bowel dysfunction clinics.

Collaborative working was needed to develop the team. This included gynaecology consultants, GP’s, nurse managers, physiotherapy managers, community contact team, lead commissioner, service provider, provider development, physiotherapy specialist interest groups, gynaecology special interest groups and PBC leads. NICE guidelines were used as pathways were developed and capacity within the gynaecology services was completed as part of the FFF Plan.

Outcome - On-going examination of patient outcomes is taking place with data audited. Feedback from patient questionnaires is very positive. Development was based on an audit done 4 years ago, when it was found that 68% of patients referred for physiotherapy did not require secondary care. It has been highlighted that in some areas referrals for physiotherapy come from secondary care, so there is obvious levels of savings to be made when this service is fully functional.

33. Redesign of the intermediate tier of service in Calderdale

Mrs Anita Hirst, Occupational Therapist and Rapid Response Manager, Calderdale PCT

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Historically Calderdale’s intermediate care services worked in isolation of each other in different parts of the town, using different referral criteria and processes for admission. Communication between different services was limited and low referral rates. It was suggested individuals were admitted to hospital where other options would have been more appropriate and a greater number of options were required for those who required ongoing short term rehabilitation on discharge.

Anita Hirst was appointed project manager to lead redesign of service, to integrate existing rehabilitation beds in nursing and residential homes along with a revamp of domiciliary part of the service, creating opportunity for step up and step down services within an integrated multi-disciplinary team. Development work included Calderdale Social Services and community based rehabilitation staff from Calderdale and Huddersfield NHS Foundation Trust. The team became operational in May 2006 and was the first jointly funded health and social care service in the area.

Referrals are via a single point of contact, using uniform criteria and assessment tools with documentation used by all parts of service. Service is available for all Calderdale residents over age of 18. It operates 24 hours a day, seven days a week with core assessment team working a 2 shift system - hours 8.30 to 19.00 and support workers working a rota system - 8.00 to 22.00.

Outcome - Team offer a responsive service for those with a physical, social or psychological change in their circumstances resulting in a temporary functional change in their abilities, or which required short term nursing intervention. The team comprises occupational therapists, physiotherapists, nursing staff – RGN and RMN, a social worker, 11 support staff and a team leader to oversee these, who in turn receives support and supervision from a home care manager.

There is capacity for 35 people to be managed in beds at any one time (15 nursing and 20 residential) and for 38 places per day on the domiciliary part of the service. Team offer short term therapy and/or nursing treatment with tasks delegated to trained support workers.

Community based staff provide 2:3 referrals, with an average 100 referrals per month. Single point of contact has streamlined this process saving on resources and improving patient experience.

The team is inspected using Care Standards guidance and were rated Excellent by CSCI.

34. Leadership Within Primary Care

Mrs Farhat Hamid, Head of Nutrition & Dietetic Service, Brent Teaching Primary Care Trust
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Farhat Hamid (Head of Dietetics for Brent tPCT) was elected Chair of Wembley Practice Based Commissioning Cluster in 2006. As such, she is one of only a handful of AHPs leading on a PbC Cluster in England. Wembley PbC Board has a multidisciplinary membership comprising 3 GPs, a Pharmacist, an Optometrist and a Dietitian. During her period of Chair, Farhat and the Board have successfully held engagement events for Wembley GP practices, led the practices in the implementation of the PCT's Referral Management Scheme and managed an indicative budget. The Wembley Cluster includes 16 separate practices who have signed up to work within the Cluster. The population size served is over 75,000.

Outcome - Brent tPCT have assessed the Wembley PbC Cluster Performance Report for 2006/07 and have agreed that the cluster achieved all of its aims & objectives. The PCT have also assessed Wembley Cluster's Commissioning Plans for 2007/08 and have ratified these plans.

35. Professional Advisor for Therapies - Physiotherapy and Occupational Therapy

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This strategic role was developed to advise a diverse spectrum of managers and practitioners across Oxfordshire Health Care community, on the safe delivery of these therapies, re-design of services and integrated planning. It has since discontinued following restructuring but remains a useful model which is being considered in other PCTs.

The post was employed within the PCT 0.6 wte, and line managed within the provider arm to work closely with service managers and lead therapists in the different service specialties / teams. It worked with the commissioning directorate and Practice Based Consortia, to advise in service delivery and re-design. It was expected to have close working relationships with the other providers of care in Oxfordshire to develop/ensure integrated care pathways and close working within the therapies. This post can be used as a consultant role to other health care providers across the country

for Allied Health Professional and development issues.

36. Inspiring leadership: Leading Across Boundaries programme

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Leading Across Boundaries is a unique programme aiming to develop leadership potential of individual pharmacists across the public and private sectors. It supports both development of robust, forward-thinking and outward-looking local pharmacy networks and discovery of solutions to important local issues. Whilst the programme is designed for pharmacists, multi-professional working can be an essential part of an individual programme.

The programme is result of collaboration between NHS Leadership Centre and Royal Pharmaceutical Society of Great Britain. It is endorsed by NHS Institute for Innovation and Improvement based at Warwick University.

Intended outcomes include: developing effective leaders, working across boundaries with colleagues in own and other professions, breaking down professional barriers, getting better value from NHS resources, improving patient safety and patient services.

37. Implementation of a Haemato Oncology Diagnostic Service in North Trent Region

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In 2003 NICE published 'Improving Outcomes in Haematological Cancers' guidance to establish diagnostic centres covering one or more cancer networks, and to provide consistency of care.

The North Trent model went live on April 16th 2007 and brings together all the key diagnostic laboratories of haematology, histopathology, cyto and molecular genetics.

Implementation involved preparation of a business case, primarily to commissioners (NORCOM) to cover revenue costs of the service, and also to host trusts for capital costs. This was a multi-professional exercise bringing together, biomedical and clinical scientists from different disciplines and different institutions, clinical haematologists, histopathologists, cancer network facilitators and business planning team. Revenue costs of £200,000 p.a. should demonstrate a rationalised cost effective approach for delivery of the service.

A key objective is to issue an integrated report from relevant laboratories. This is done using web-based software that allows access to all referring and receiving laboratories and by heavy investment in multi-disciplinary team meetings (MDT). The service is in early stages but already has seen significant opportunity developing for Biomedical Scientist Staff. A diagnostic MDT is held weekly and is now chaired by Senior BMS in Haemato-Oncology Diagnostic Lab.

Outcome – There is compliance with the IOG by receiving samples from all South Yorkshire Trusts. Diagnosis is confirmed initially at a scientific MDT followed by a clinical MDT, which is video conferenced to the DGH's. Turnaround times, which have improved through use of additional funding, are monitored to meet cancer waiting time targets. Diagnostic accuracy on **all** patients with haematological malignancy is improved.

38. Multi-professional Development of Clinical Pathways

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Consultants, GPs, general manager orthopaedics acute Trust, PCT managers and orthopaedic physiotherapy practitioners (OOP) were all involved in developing pathway. This meant there is less time spent dealing with professional barriers to new service delivery

Referral pro-forma were developed by OPPs, consultants and GPs to ensure appropriate paper screening that would ensure patients are managed by most appropriate professional, at right time and place. Pro-forma were piloted within practices prior to service going live.

Clinical pathways are in process of being developed, which will facilitate best use of diagnostics in primary care e.g. What is added value of access to MRI in primary care? Will it reduce the need for procedures such as arthroscopy or will it just add another step and end up being an unnecessary cost to health community? The big advantage is that, although service is based in primary care, collaborative work between OPPs and consultants will ensure a seamless journey for patients. It will avoid duplication and unnecessary delays. This will maximize utilisation of resources and speed up pathways to assist PCT in delivering 18 weeks

Joint working between acute Trust and PCT has facilitated ability to better direct referrals, which OPPs assess need to see particular consultants with particular specialties i.e. OPPs can advise

admin team, which particular sub-specialty patient requires. E.g. lower limb versus spinal versus upper limb. This ensures patient seen more quickly by appropriate consultant. Patient is less likely to need to be passed on, minimising wasted consultant appointments and speeding patient through 18 week journey. This was easier to achieve as there were good clinical between OPPs and consultants and they were familiar with each others work.

39. Redesign of the Ophthalmology Pathway across Brent

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Analysis of referral patterns showed majority of GP practices in Wembley PbC Cluster refer all patients requiring acute ophthalmology care to local acute trusts. There is a strong evidence base to suggest much of this care can be provided - cost effectively and to same quality standards - in primary care. Wembley locality created over 7,000 hospital ophthalmology episodes last year. There were a further 660 visits to accident and emergency. In a recent paper, Department of Health has shown 76% of such episodes can be treated in a primary care setting.

Wembley PbC Cluster worked on a business case (written by optometrist board member and dietitian chair of cluster), which offered 3 potential ways forward:-

1. Ophthalmology service provided only by local acute trusts i.e. no change to current provision
2. Service to be provided by the cluster employing a community ophthalmologist
3. Service provided by accredited community optometrist with specialist interests (OSi's) with a community ophthalmologist on a session basis. Introduction of Primary Eye Care Acute Referral Scheme (P.E.A.R.S)

PCT commissioners have shown a keen interest in this business case and have asked Wembley Cluster to consider whether this service redesign could be widened to cover whole of Brent PCT area – so Brent ophthalmology pathway is redesigned. This has potential to offer expert care at more convenient local settings for patients and significant reductions in cost of ophthalmology treatment within acute care.

Outcome - Business case for redesign of ophthalmology pathway in Brent will be taken to Brent tPCT Board in September 2007. If ratified, new services will be launched from January 2008.

40. Re-design of rehabilitation services in central Manchester

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Research lead by AHP manager studied utilization of in patient rehabilitation beds. It identified up to 55 beds were occupied by patients who could have been managed through investment into alternative community provision (e.g. community sheltered/transitional housing, home based services, community intermediate care beds, community nursing home beds), and reduction in hospital beds. The research involved acute Trust, PCT, local authority housing and social services

staff in liaison with patients, full multi-disciplinary team involvement.

AHP manager worked with social care lead to identify strategy for reconfiguration of rehabilitation services across health and social care. Strategy was refined/developed via large stakeholder project group. Implementation of strategy was driven via PCT/social care and housing services.

Outcome - Development by PCT/social services of a home based health and social care rehabilitation service and sheltered housing access from secondary care. There has been an expansion of community intermediate care beds and a reduction in hospital based rehabilitation services.

There are fewer delayed discharges, a greater range of services available to patients and access to home rehabilitation.