Manage Backs Group Intervention

Applying a biopsychosocial explanation of LBP at physiotherapy care pathway entry in primary care.

Moses J., Oliver G., Paul-Taylor P., Hurst S-L.
Physiotherapy: Low Back Pain

Dichotomy within the profession: Hands on vs. Hands off

Hands ON

Hands OFF!

IFOMPT CONFERENCE 2016
4th – 8th July 2016
Change the first contact with Physiotherapy

How does physio practice need to change?
Introduce a group intervention instead of 1:1 assessment
How did we support delivery?

• Co-produced a delivery framework including:
  • Operational
  • Training
  • Evaluative

• This support allowed GI’s to be delivered
  • Fast: Ave. wait 3.5 wks from referral to GI
  • Across the Health Board: 85 GIs over 6 sites
  • Widely: >600 patients attended a GI
What did we find?

- Improvements seen in all measures
- Greater changes in Activation in people who attended Manage Backs
- Over 83% found it useful

1. Clinical Outcomes
Mean change in measures
What did we find?

Reduction in:
- NP 1:1 DNA rate
- 1:1 NP:FU ratio
- Re-referral rate

Pathway activity
- 13-25% following attendance GI

2. Prudent healthcare

Pathway delivery cost PA

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<th>Thousands</th>
<th>£200</th>
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<td>Traditional</td>
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Savings equate to:
- Up to 28% pathway cost
- £48k within CAV
What did we find?

Training framework:

• External and local elements.
• Mentoring programme

• Good opportunity to discuss & overcome barriers with complex patients – posted us in the right direction. Gave us support. (Participant 6)

3. Staff attitudes & beliefs: Mentoring
Perceived improvement in competence (80%)
What did we find?

HC-PAIRS (Higher scores – beliefs re pain placing more limitation on function)

Health Care Providers’ Pain and Impairment Relationship Scale: HC –PAIRS (Houben et al 2004)

4. Staff Attitudes & Beliefs: Quantitative
MB’s began to gain wider stakeholder acceptance including:

- Patients
- Clinicians
- Services

There is huge power in patients learning from each other

The initial conversation is much different...... they are already starting to make changes and doing things differently

Already on initial outpatient appointment the patient is on board

It is changing people’s perspectives of LBP
Patients…..

“I found the whole session very good….I came home to my husband and said I’m so much happier... It put my mind at ease...particularly hearing other people’s experience. I felt as though I was in a safe place.... I felt happier in myself somehow...You don’t normally get the opportunity to say these things to people even though I have many friends, good friends, they are all very nice and sympathetic but they don’t really want to hear it. If you haven’t experienced it (LBP)...it’s hard to relate.”
Summary & Limitations

- Used co-production to develop GI model with stakeholders
- Manage Backs GI model:
  - early care pathway intervention
  - BPS explanation, permission, signposting and PLBP shared experience
- Developed an operational, training and evaluative framework
- Staff beliefs and activity levels: impact of the model?
- Delivered MB GI model, mentoring and BPS package
- Achieved LBP pathway transformation
THANK YOU......

DO YOU HAVE ANY QUESTIONS?

What did we find?

4. Staff attitudes & beliefs: Qualitative

I’m happier. I have more confidence in saying I can’t cure you but this is how I can help. Before that I was trying to be a physio who made them better.

If a patient said ‘I’m stressed’ I would just write it down.

My questioning style has changed; I delve into more psychosocial issues deeper than I would have previously.

I used to feel pressured to come up with a diagnosis, thought I wasn’t a good physio if I couldn’t.

The ‘Future conversations’ slide was very powerful (where to go and different options). I’ve learned to do this straight away now and don’t wait to the end of my treatment to tell the patient.

The hot cross bun slide was key to the whole process.

Our bio-psychosocial thought process and clinical reasoning is better.
Conceptual model of struggle (Toye et al 2013)
Toye et al (2013) Moving forward model