BRITSpA Travelling Fellowship Salford 26-7th June 2023

Host site: Salford Royal Hospital, Northern Care Alliance NHS Foundation Trust, M6 8HD

Travelling Fellows:

Rebecca Adshead – Rheumatology Department, Whipps Cross Hospital
Zoe Cox – Royal Hallamshire Hospital, Sheffield Teaching Hospitals NHS Foundation Trust
Emily Deeney – Rheumatology Department, Gateshead Health NHS Foundation Trust
Paula Dowie – Rheumatology, Whyteman's Brae, NHS Fife
Sarah Fish – Rheumatology Dept., Minerva Centre, Lancashire and South Cumbria NHS FT
Rhona Galway – Physiotherapy Dept., South Eastern Health and Social Care Trust, Northern Ireland
William Gregory – Rheumatology Dept., Salford Royal Hospital, Northern Care Alliance NHS FT
Heather Harrison – Physiotherapy Dept., York and Scarborough Teaching Hospitals NHS FT
Rhys Hayward – Rheumatology Department, Northwick Park Hospital
Clare Longton – Rheumatology, Royal Lancaster Infirmary, University Hospitals of Morecombe Bay NHS Foundation Trust & Rheumatology Dept., Blackpool Teaching Hospitals NHS Foundation Trust
Maureen Motion – Physiotherapy Dept., The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Catherine Tonks – Rheumatology Dept., University Hospitals Coventry and Warwickshire NHS Trust
Dr. Carol McCrum – Division of Allied Health and Division of Medicine, Canberra Health Services, ACT, Australia

Day One – MONDAY 26th June

Session One -1100-1200 - Janet Milner – Physiotherapist, Tasmania, Australia, and Lead Author of "Exercise for AS: an evidence-based consensus statement" 2016 – **How we did it and why? Followed by Q&A.**

Session Two – 1145-1330 & 1400-1530 x 12 individual presentations - part one.

Session Three - 1630-1730: guest speaker **Dr Lesley Kay** – GIRFT national lead for Rheumatology

Lesley has visited all of the country's rheum clinics so far bar 9; MDT is high up on the list of GIRFT rheumatology of what the teams are proud of, and awareness of poor recruitment in the MDT in rheumatology. 1/3 of referrals seeing non-inflammatory rheumatology - is no evidence that adds better outcomes than primary care management. Wait times across the UK from 4 weeks in some centres to >30 weeks in others, with some >52 weeks. Lesley believes those waiting > 52 weeks are coming to harm and that new patient slot does not improve their situation / issues. To make services more effective: (i) move the non-inflammatory into local services with shorter wait times, no need for a medical lead, (ii) use of Specialist Advice (formerly A&G) to progress patients to the next step. The 6 week start to meds is the key target.

Day Two – TUESDAY 27th June

Session Four – 0845-0930 - Preparing for an Axial SpA service. **Presenter 13**

Session Five – 0930-1015 - Theories of Consensus Building – Dr Carol McCrum

Session Six – 1030-1230 – group work on consensus building inc. PPIE.

BREAKOUT 1– 1030-1100 **-** 3 groups creating "gold standard" pathways and considerations of how we support the physio-led Axial SpA screening service.

PATIENT VISITORS - 1100-1130 - Joined by 2 of our patients at Salford who talked through their experiences of access, diagnosis, and ongoing care in their rheumatology departments.

BREAKOUT 2 -1130-1230 - Further work on groups "gold standard" pathway and presentations back to team.

Session Seven – 1330-1445 - "top 5" exercise and wrap up/next steps.

Travelling fellows were asked to reflect on the visit and their "top 5" learnings. There followed discussion and creation of a list of issues raised to embed the learning and point towards future projects ..

1. **Although there are differences in services, similar challenges.**
2. **PT-led AxSpA service shouldn't be undervalued.**
3. **Balance between clinical and non-clinical time**
4. **Support and Evidence**
5. **Each area is commissioned differently->diff staffing models, this variation must be considered in our recommendations.**
6. **Variances in practice are noted, but same outcome - good example of different application.**
7. **Role in Specialist Advice (nee A&G)**
8. **Consider how we feed into our physio teams.**
9. **Need to be mindful of where we go above and beyond medical model (rather than our limits compared to medics)**
10. **When do we scan?**
11. **Must be band 8 - query local context or developmental role (but always compared to previous staff role)**
12. **Slot duration =45mins (but ? length of AxSpA diagnosis appt FU)**
13. **Succession planning**
14. **Does conversion % matter versus "added value" to those patients care?**
15. **Role of HLA B27, should this be standard for all? is it more useful for those with a negative scan.**
16. **Confirmation of what we are each doing.**
17. **4 pillars, SPA, job plan, 70:30 ratio**
18. **Specific supervisor in rheum +/- in physio**
19. **Break through the consultant physio ceiling.**
20. **Consistent referral criteria**
21. **Patient engagement with this process is needed.**
22. **Develop our business case skills and be more active on this. Consider securing funding for this and for the rehab part of the AS pt role.**
23. **Stop being imposter-y. We are good enough and have the skillset and scope.**
24. **Need to link to the comp framework - value in the role/structure.**
25. **Integrated member of the rheum team.**
26. **Recommendations need to be worked through in local context.**
27. **Parity in admin/nurse support etc. - must stipulate this.**
28. **Good to see local variation in how this is delivered, but same challenges.**
29. **Essential that we'd clarify our roles and responsibilities - re. accountability and scope of practice**
30. **Stepping into a brand-new job, what is extra, what hasn't been supported.**
31. **Rheum PT specific succession planning, very much the FCP exodus (limitation in our paper!)**
32. **How are we measuring our impact (and do we measure our "failure")**

33. **Flare support**
34. **Enthused and motivated again.**
35. **The need for / not of NMP in this role**
36. **Pre-scan chat - e.g., how do you want to be contacted.**
37. **How we give back MR results**
38. **Screening in primary care - does this link to conversion rate?**
39. **Being the point of contact for PIFU, flare, etc. how do we explain this fully e.g., nurse advice line leaflet.**
40. **Lone ranger, can't do everything.**
41. **Training your sec/typists about some of the more physio specific terminology.**
42. **Feel validated in the role - similar level.**
43. **Allowing a longer time for the diagnostic advice slot**
44. **Pre-scan advice - what if results are indeterminate.**
45. **Consider stakeholder involvement about our services - what is important to the people we serve.**
46. **Band 6s coming into the rheum PT rotation.**