Academy of PHYSICAL MEDICINE

# A 7-Point Plan for Functional Rehab - Ref 94HW - Draft Transcript

*with Heather Watson*

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## TRANSCRIPT

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- *Some elements (repetition or time-sensitive material for example) may have been removed*
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**Steven Bruce**
We like to vary the content, as I'm sure you're aware of the academy here. But we also like to make sure that we're ticking off the boxes on the osteopathic practice standards in the chiropractic code. And if you take the trouble to look into those, of course, you'll be aware that we are required to ensure that we are helping patients to help themselves. We're also required to monitor their progress and keep a check on it and address our treatment accordingly. And that's what I hope we're going to do in particular today. And I am joined for that purpose by Heather Watson. Heather, how are you today? Hi, I'm good. Thank you very much. Thanks for the invitation, Stephen and your listeners. It's great to have you with us your home, you probably don't like to admit how experienced a physiotherapist you've been in this business for well over 25 years in the functional rehab business, haven't you and you also specialise in fitness for work as well, which is directly relevant to of course what we're trying to do with our patients and my writing.

**Heather Watson**
Yeah, that's right. I started out with a little bit of Occupational Health experience when I was a student. Well, I'm sure you guys are the same. We have elective placement. I ended up working at the rover factory in Birmingham, that was where my interest in occupational health started. Okay,

**Steven Bruce**
and since then you've set up your own business which is designed to move which we've got here, which is designed to move.co.uk with a number two in the middle. And what we thought we would look at today is I suspect what is for you a fairly simplified form of rehab, which is sort of seven stages. I thought that appealed to me because my own I speak purely for myself and I've always felt that as an osteopath, I was particularly ill equipped with the stuff that went on beyond the the clinic room, the treatment room, and I wasn't very good at rehab. I suspect I'm not alone in that position. And, like many people, what I like is to have a nice fixed plan that I can adhere to so you're gonna seven principles here.

**Heather Watson**
Yeah, absolutely. You're right. It comes from, you know, again, traditionally, I've made very clinic based in the past and even in occupational health and people tend to come to the clinic, but the greatest advantage of Occupational Health when you work for a business is that you get to go and look at the work and into the workplace and see and feel the environment and see the real tasks. And so really with designed to move, we just extended that out as well beyond work. And, you know, looking at what are the tasks people do? Where possible, if it's a clinic environment, looking to replicate the task, as best you can to simulate it, obviously, they're the real deal, the gold standard is to go out and see it for real and see the person perform it in the real context that they work in. So we aspire to that, and where, where we can't do that where you know, current situation included them, we will find ways around it.

**Steven Bruce**
How often do you find that it's actually necessary to go out to somebody workplace because most, most jobs are fairly predictable, aren't they sitting at computers is probably I mean, it's the same across a whole variety of different industry.

**Heather Watson**
Yeah, I suppose that's a key difference actually, that you know, if you are talking to somebody who has an office space job, that's something that actually you can do a lot of remote advice. For, and it's more often than non computer jobs that need to be viewed, you know that you need to go and see or ask at the end, if you can't actually go and view the workplace, ask them to take some pictures or describe it to you, or even you know, give them a few props in the clinic room and say, you know, could you just show me how that task flows and what movement you would use to achieve that? So, the reality is that with design to move, we see some people in the workplace, but we spend a lot of time going to people's homes, or we go to the gym with them, or we go to the local park with them. So we work out one of the most relevant tasks that they're struggling with, where do they do those and then we aim to go to the location. Right, very variable, very interesting,

**Steven Bruce**
but it's also very time consuming. I think your your, your your in house team it's designed to move is actually quite small, isn't it?

**Heather Watson**
We have we have an in house kind of leadership team of just four of us to clinicians and to business port. And beyond that we have a freelance team of physios that extend to around 30 people now around the UK. And, and certainly the our full functional rehabilitation model is very time intensive. It requires visiting the person at home or at these locations. But it feels a real need actually for especially for complex. People got complex injuries or a complex condition. Because it's often what's been missed by maybe traditional clinic based approaches and NHS based approaches. So we, although we can step in early, and it's obviously great for us if we can sometimes we're a follow on later when certain tasks haven't been accomplished and still outstanding as a goal of the client.

**Steven Bruce**
So what are your freelance physios doing? are they available to other practices to go out to the workplace and basically do this do the assessments for those other practices

**Heather Watson**
and not at the moment so they do all work for other people and so we Have clinicians who work in the NHS the rest of the week who have their own practices in the NHS the rest of the week or work for private MSP providers usually. And so they have a whole variety of other work. And then at the moment, and this may change in the future, but they'll they'll do their work for us the purely freelance basis and then go out and see these clients individually. Okay,

**Steven Bruce**
well, we'd better get on with your principles, haven't we? Because my experience of these lunchtime Sessions is that we rapidly run out of time, especially when the questions start. But before we do that, just a quick

message for my admin team working behind the scenes. I'm still not seeing the right cards on the question sheet. So if somebody could address that, for me, that would be helpful to see. So your first principle then.

**Heather Watson**
So individualised programming, I think what's really interesting about the history behind functional rehabilitation, and that this is a phrase we use that can be muddled up, and interchange though with other things. Like pain management programme functional restoration, work hardening work conditioning, there's lots of different phrases, we try to stick with functional rehabilitation because it hopefully says what it does on the tin. What's important is that in some places, and a lot of the research behind some of this is about group based programmes. Certainly in the States, it's very traditionally done as a group thing, you bundle a whole people in a room and you put them through eight hours of something five days a week. But what we do and I think what still happens in those group programmes is each individual has an individual programme based around their needs, their goals, what they've got to achieve. So there may be a framework that may have certain topics in it that you may cover all of, but you may only cover some of them. And the order in which you cover them will be determined by the needs of the patient and the stage that you're at, rather than just pushing every client through the same programme.

**Steven Bruce**
I guess It's, it's a well known criticism of the standard rehabilitation model, isn't it? I don't want a single physiotherapist out for this. physios happened to be the ones who were in the NHS and therefore we get them. But it's the reach into the box and get the set of exercises which you give to everybody who has lower back pain or whatever. And I suspect that the scope for varying those exercises is fairly limited. But well, perhaps you can you can enlighten me. I mean, how much

**Heather Watson**
can vary? Or do you usually Yeah, usually. So that's probably very traditional in physio, and as if you found yourself in an NHS department, there might be a knee class or a bat class that your client would be put into a generic class which might be a circuit, but the distinctions with those exercises on and the individual bits of it would be how many reps or weights that individual person does. But yes, there is you know, there are as many exercise variations as you can think of, which means millions and how we reach the goal is to determined by how do we best motivate that client? And you know, so we pick what is important to them what is relevant how we can link it to their final outcome, rather than basing it on? Well, that's the standard exercise for the knee strengthening. That makes it much more interesting for everybody.

**Steven Bruce**
So it's not, it's not necessarily a different exercise, just because you happen to have a different job is based on your own mentality and your own aims and capabilities, perhaps.

**Heather Watson**
Yeah, so be determined by the therapists skill set, and what the client needs and what the client likes. It might be that you have a client who loves going to the gym and is not motivated at all by doing a home

exercise. And yet a very simple home exercise could fulfil the need. But we'll probably go further. Let's get them in the gym. Let's get them in that environment. Let's get them into that because we want them to get on with it.

**Steven Bruce**
Patient compliance isn't it and I suppose we all we often think of it as the other way around that little old Mrs. miggins doesn't want to go to a gym. Full of sweaty, torn t shirted muscular individual. She might do the home exercises, but of course, yeah, there are other people that really don't feel they're exercising if they're only doing it at home. It's got to be in that. mirrors. Yes.

**Heather Watson**
Yeah. Yeah, that's really the key to

**Steven Bruce**
one of our viewers are sent in a question where they knickers said that referring back to the model you described at the beginning that it sounds like an optimal way of doing things. But how on earth do you price it and still make it?

**Heather Watson**
Well, yes, so that, you know, I can imagine that that's a challenge. And I have to say that in my first incarnation as a self employed physio, I had what I would call a traditional physio clinic outpatient, Mfk clinic, you know, very similar, I'm sure to many of your listeners. And it was okay. But I just thought that I'm not getting to do the kind of work that I love to do. And without going into too much detail over the history behind designed to move is that I personally know that I really benefit from moving and that that was a priority to me. And what We've done is create a service that is very niche. In some ways our customer bases quite a small customer base. And we really specialise in the complex clients for whom there is sufficient funding to invest in a programme like ours, it is time intensive, there's a lot of hours put in, but that means that our therapists have the opportunity to really use their skills and do their best work. And the clients who need this level of intensive input have have an avenue to get it. So yeah, it is a very different business model.

**Steven Bruce**
interesting use of this funding available users mean they're wealthy clients or they're insured, or is the government funding for some of these loans?

**Heather Watson**
At the moment, primarily, it is insurance and claim driven so personal injury type clients. Yeah, yeah, that's where we found that funding. And I think they're probably actually there probably is a bigger private market than we may all think. Basically. Some of the other companies that we know about that do similar but different things. I do think there's a private market out there. And there's just there's lots of governance reasons, actually, that we haven't ventured into that at the moment. But who knows in the future?

**Steven Bruce**
where you're from, put a second as your second principal problems. We've we've done a whole 90 minute evening session on problems in the past that run us through your approach to that.

**Heather Watson**
Yeah, so problems is really important to us for several reasons. So firstly, is setting a baseline

**Steven Bruce**
and of course finding, explaining, I don't think there's anybody out there who doesn't know what problems is, but patient reported outcome measures is yes. fit on the slide in full. So,

**Heather Watson**
you know, we do kind of divvy this up a little bit further in that what we tend to talk about is body part related problems. So that might be also the street back index. And, or there might be something more generic like a self efficacy scale. And then we also use We've got a separate point on goal setting, but we would use the patient specific functional scale or goal setting. So we look at the problems we select based on the clinical case presentation. We also routinely use a trauma screening questionnaire, to screen for PTSD because a lot of our clients have suffered a nasty injury. And what's really important about a functional rehab programme that is underpinned by you know, what we know works from systematic reviews, all those sorts of things is that you measure stuff. So what we want to do is take a baseline are the beginning, when we assess somebody and say, right, this is where they're at. So that then we can say if this is where they're at now, point A, these are the goals they want to achieve. And this is how we're going to measure those and at point B, we will read perform redo these problems, so that we can give some objectivity because it's obviously not fully objective because a lot of these are subjective reports. We can give some objective view of progress.

**Steven Bruce**
That's one of the things that we discussed at length in our evening broadcast on promises. structuring the questions is really very, it's a very skilled art, isn't it? Because you need questions which don't drive a patient down one route or another and genuinely give you as objective feedback as you can in terms of their outcome. But I presume I mean, you're using your self design problems in large part,

**Heather Watson**
well, no interest, we probably use it, we use a combination and we do rely quite heavily on research and validated questionnaires when we're talking questionnaires, because because that brings, you know, gravitas and research background to it. Obviously, because of the uniqueness of our clients, it may be that the research that was done on that problem, it's not directly applicable to you know, it might have been carried out on Parkinson's patients over 70 but this person is, you know, 45 for the leg fracture thought The principles are there. And we also have quite a lot of these you have some normative, you have some data behind it about, you know what, what sorts of questions are good questions and you also have some of

them categorised. So the oswestry index, for instance, categorise, you know, mild, moderate, severe, things like that. So we do use that to bring that level of objectivity as far as we can. It's not obviously, as everyone knows an exact science.

**Steven Bruce**
Are you finding that insurance companies want to see these sort of reports? Are they just not interested? They see seven sessions 10 sessions or whatever, and that's it

**Heather Watson**
varies. It varies a lot. And I think that's one of the downsides of, you know, clinic based Mfk care that sometimes they ask you to fill in all these things. They're not giving you any extra time not paying you any extra more money. And then you don't actually get to see what they do with the data. And you feels like it's not relevant. We, we've created a service that means it packaged in we've we follow this up, we make sure that we really measure it, it becomes our data as a business to demonstrate that we're being effective as a service.

**Steven Bruce**
Yeah. So the variety of validated questionnaires that you're using, are you able to share any of those with today's audience?

**Heather Watson**
Yeah.

**Steven Bruce**
I mean, they part of the E book that you you've got up

**Heather Watson**
with not wanting selasa detail in the book, we have touched on a few and the course that we'll talk about in a bit, we'll go into some of them in more depth, but it's a lot of the stuff that's easily accessible out there. We don't use anything really unusual so deals with stress on the dash disabilities on hand scale, upper extremity and lower extremity functional scores. And they're probably our Biggie, big key ones back pain. And the the patient specific functional school we use a lot and then we use a few like the trauma screening questionnaire, the array bro One repo is a big one because it's a yellow flag, psychosocial screening questionnaire. I use that one a lot. We've been playing around a bit with the NSA HQ. It's difficult some of our clients have more than just Mfk as well. So we we, we select, they have a lot to fill in. We try not to overdo it, because it's a nightmare for the client. And it's a nightmare for us to analyse the wall. But yeah, I mean, so we're not we've In fact, I don't think at this stage, we use anything that's not out there, available to everybody.

**Steven Bruce**
Okay, well, I'll try and summarise the things that you've mentioned for the people watching this and the recording and put them on the on the summary of what goes on. But I'd also drive them towards both the

end call the osteopathic Research Organisation and the Royal College of Chiropractic have done their own investigation into validated promising personally and I speak as an osteopath. I find the Royal College of Chiropractic is one much more accessible than the osteopathy, one. But well, I'll give people links to those two as well.

**Heather Watson**
Yeah. And I think you know, the principle there is that you select something based on the fact it's going to give you the meaningful information that you need. And you know, some people say to us, well, why don't you use? The big one that's been used in physiotherapy in the NHS is the EQ five D. And for me, it's just too blunt at all. It may be great for analysing 1000 or 2000 or 10,000 clients across national contracts. But for us, it's, it doesn't help

**Steven Bruce**
if I have any problem with patient compliance, because I've always worried that when you get long form forms, patients get bored and they don't want to do it, especially at regular intervals so you can monitor progress.

**Heather Watson**
Yes. We try to prepare our clients that this is a different type of service that this is going to be a lengthy, some possibly frustrating experience. But it's important so we prep people and they generally a programmer Standard programme, our usual programme is around four months, they'll generally do them at the beginning and at the end. Yeah, we might do a couple in between, we might update something like the goal setting one as we go along, but we won't ask them to do them too often.

**Steven Bruce**
So what's principle three functional measurement?

**Heather Watson**
Yeah, so this is kind of the, I suppose is the other arm of it, we have it, you know, we have an interview with maybe three arms, we have the interview and the subject of history and getting you know what, what their situation is, and we have the prompts to get some subjective or objective measures. The functional measurement is about actually getting them to do some functional tests or activities that we can measure. Again, there's definite dividing here between there are a bunch of tests out there that have been tested, researched, validated, and all the rest of it that would fall under what people might have heard of as functional capacity evaluation approaches. And in many cases, that can be actually a battery of tests. It can take up Anything from a couple of hours to a couple of days in its most extreme form, which may sound crazy if you've never come across it before. But the other side of that is that this can be very simple. So if it is this person saying, well, I can't get it out of my kitchen cupboard with ease. And I'd like to find a better way to do that because I need to be able to do it three times a day, then we would create a test around measuring the ease of movement to do that three times a day. And you'd make it highly valid to that patient.

Keep it very practical and very simple. But it would have no research base or validity. Outside of that context,

**Steven Bruce**
is the test not simply we'll go home and do it three times a day. And did you find it easier today than yesterday?

**Heather Watson**
Well, that would maybe be the homework. But the tests that we want to say at the beginning as they're saying to us, I want to be able to do that by the end of this rehab programme and at the moment, my turn I can't do it at all. Or they might say, I might be able to do it, but I'm scared of doing it. So I don't do it. So that test result would be zero out of three possible options a day, because they won't even do it. And our goal would be to have them demonstrate to us at their final visit that they are able to do it three times in succession, and therefore three times over a day or, you know, we'd like to see it, they might have to report it in the current circumstances.

**Steven Bruce**
Mary's just sent in a question asking for a list of those questionnaires. But as I said, I will I will try to summarise them from what you've given us already and add in the osteopathic.

**Heather Watson**
I mean, I'm sure you know a great resource for things like that. And that you might you might have something equivalent, so apologies if you do but the physiopedia website is a sort of place where you could, you know, put in the titles of these questionnaires and get a really great summary of their history, their research base and where to find the copy of them.

**Steven Bruce**
About your functional measurement better than most of the tests that you create bespoke to the individual.

**Heather Watson**
And probably probably good 5050 I think we can we use some routine tests that are really simple to administer. So one A good example would be the time sit to stand. And there are a couple of different ways that this can be done. But essentially, it is the time taken to stand up and sit down 10 times from a chair of a standard height, which in theory, you could measure and if you were using your clinic, you just use the same chair every time. If we're doing it with a client in that home, we would just make sure that we use the same dining chair every time. And the nice thing about those tests is that you can go and say okay, it took me 20 seconds to do 10 sit to stand. How does that correlate with a female of my age? Who is not injured? Now I know 20 seconds is a lot higher than somebody of my age that is an engine it probably should be near 11 seconds. So we would document it took them 20 seconds to do that. And actually, that is outside of something for an uninjured person. Obviously, our clinical reasoning would say, we may not expect them to get back to the same speed as a non injured person. But we'd expect to see an improvement that would be

realistic. And what the time sit to stand demonstrates is lower limb strength. So it's an indication of lower limb strength. That's the standard one we would use and walk tests. Brilliant six minute walk test, two minute walk test. Pretty easy once you've got a piece of string and a stopwatch.

**Steven Bruce**
Yeah, sorry, I was just thinking you're gonna see how long does it take you to do a six minute walk? Well, that's probably not your measure, is it?

**Heather Watson**
Nobody's great measure because of course, some of the clients we see are not going out walking and it would terrify them to do six minutes. Two minutes,

**Steven Bruce**
I guess. I mean, it could be any length of time, but I mean, I presume that A six minute walk is probably a good measure. Because if people if people are capable of walking much further than that, then they probably don't need their walking assessed to do it.

**Steven Bruce**
Are you there?

**Heather Watson**
Yeah, it's interesting, because, yes, there was a little bit of delay there. And the six minute walk test gives you a result, which is correlated with height, weight and age and gender, and is a prediction of that that calculation gives you an indication of how far you would expect them to walk in the six minutes, which is an indication of their fitness. So you'd expect someone to perfect to walk their six minutes much faster than somebody who isn't. So we would still put someone through it, for example, a 19 year old champion at a lower nasty lower limb fractures, we'd still put him through it in the same way we might put somebody in their 60s who's mainly house bounds not really going out, but could think they could do six minutes before Put them both through the test. Because we can work out what their predicted distance should be for their group their what it should be. And that, again gives us a line of where they are versus what they should be capable of if they weren't injured.

**Steven Bruce**
This is a this is slightly puzzled me because you're emphasising there that you put them through the test. Whereas I imagine you send them home and said, Good walk for six minutes and see how much further you get. If you're doing that, then you've got to have a nice clear route that you can put them around predictably every time. So how are you doing? How do you test yourself? That's

**Heather Watson**
a really good question, Stephen. Yeah, I mean, so yes, we normally when we do an assessment, covert aside, we would be going to the client to the probably their homes, do the assessment. And we would take them

through these tests. And so the functional capacity evaluation background is that these tests should be done in an extremely controlled and repetitive repeatable way. We don't take it quite that far, because that's really actually very difficult to do. to standardise unless you have a clinic or a gym and things like that. So what we would do then the easiest way to calculate it is I take a piece of rope that is 10 metres long and I place that along the pavement that's we need a flat pavement so you have to kind of scout out the area you place that down and you get them up and down up and down the 10 metres for six minutes and you've got your stop watching you also taking things like rate of perceived exertion if you were to follow it to the letter, you would also be taking a pre and post heart rate and things like that. So again, it's about making it practical and then you can do it no matter what

**Steven Bruce**
yeah, I mean that's that's a 10 metre repeated walk that's

**Heather Watson**
boring.

**Steven Bruce**
is boring is is quite challenging just because it's boring, isn't it? But of course, you've also got lots of turning involved in it, which challenges the body in other ways if they've been injured.

**Heather Watson**
So the other thing we are I mean we're taking in and any therapist would be taking in as the quality of that movement so that their score might be in keeping with what we'd expect that their time. But if actually the way they're moving is not great. They're off balance. They're this sweeping around along with line. That's still something that we would probably want to work on.

**Steven Bruce**
Sally's asked whether you co manage with your psychotherapy colleagues, especially with the yellow flag patients, manage such a tailored approach. Hmm,

**Heather Watson**
yeah. So the bigger context to our business is that we are usually one part of a multidisciplinary team because these clients complex clients, they inherently have yellow flags, some of which are very what I would call, you know, physically based that we as physios can very easily manage around maybe movement and fear avoidance. Some of them are much more complex, you know, psychological things that need psychological support. So in simple cases, We may get on with our bit and there may not be any other professionals involved. With more complex cases, there will be OTS, there will be psychologist, neuro psychologists, there may be support workers. And we don't provide them. We are commissioned by what's called case managers. They then sauce each of these different types of therapists, we then work as much or as little as as needed as a team to support the patient. What we do do, quite actively, is if when we first assess somebody, we identify potential Post Traumatic Stress Disorder, we don't diagnose it, we just use a

screening form that says, we think more more assessment is needed. So we might flag up if they haven't had a psychology assessment that they we think they should, because that will affect the outcome of the programme and the rehab for them. And if they are having psychology, and all We think as we go through that there's some stuff that we really can't address. Again, we will flag that to the case manager. And we will have interactions, joint sessions. whatever we need to do.

**Steven Bruce**
Someone has asked and I don't know who it is, they've asked how you find it, how you manage it dealing with so many different professionals.

**Heather Watson**
Well, that is one of the reasons that we don't do that. So at the moment, we provide physiotherapy delivered functional rehabilitation, because we are trying to regulate our own delivery based on the hcpc in the CSP standards. And much as of course, some of those are very similar across professions. You know, I wouldn't know where to begin regulating with a psychotherapist. Um, so that's why the case manager brings together the team, we are one part of the team.

**Steven Bruce**
So have you got any suggestions for people who don't work in the sort of about sort of privileged environment that you're in because most of my audience, osteopath, chiropractors, they are likely to be in nicely isolated clinics. If they're not operating on their own. Then there'll be operating with other osteopath, chiropractors and maybe occasional, they'll have some talking therapists in the clinical and so on.

**Heather Watson**
Yeah. And well, I think, definitely it's about making those connections, isn't it? So even if we don't, we wouldn't be the ones going out and saying, Please, we might suggest a psychology for example, that's our most common suggestion would be this person that we think needs a psychology assessment and is going to need some support. And we may have people that we've worked with before, through our networks that we know that we both understand the way that we work our practice and that we complement it. And so we might suggest, you know, this person would be a great piece of person to speak to. And I think that's one thing is building your own immediate professional network. Least because then you can ring someone and say I'm having this challenge with this client. Do you think it sounds like they would benefit from a psychological assessment? And if your psychotherapy colleague says, Yeah, that that definitely sounds like it needs some professional intervention, then that means we can escalate it. So that's how we would work it, we'd have that network. We've got a little advisory board, and we've got a person on there, that's an occupational psychologist. So we might go, what do you think of this? And she goes, now you really need to get someone else involved with that. And that means that we can then make that suggestion back to the funding and referring party. You obviously don't necessarily get to work with people that you know or would like to but at least the client gets an assessment and some support.

**Steven Bruce**

Heather we better we better move on a little bit, haven't we? Time is getting on as it always does. And your next point is on goal goal setting.

**Heather Watson**
Yeah, so you know, this maybe sounds really simple. It may be really awful. But it's really important. And it's very easy to actually with our practice, if you can hear it, it's probably quite easy to actually lose track of the individual client that we talked about at the beginning. Because there's this structure around it, and there's potentially all these other professionals involved. It's quite laborious just to manage the thing. And, but really, this is what we come back to every time is, what is it that the client wants to get out of their rehabilitation programmes, their life, it's their life that's been interrupted, whether that's by illness or injury, what is it that they want to do? And so we want to elicit a conversation around them maybe based on activities they did before they were injured or ill and that they want to return to, it may be leisure, there may be work, it may be family, it may simply be we're walking their child to school. So this is about making sure that we ground our plan in what's meaningful to them, rather than what's meaningful To us, you know, we could we could create a beautiful looking exercise programme that takes them up through, you know, a lovely structured exercise plan that we like, and we take the box off, but if they still can't walk their child to school, because they're worried about dripping on a curveball, it's a bit further than the six minutes or that we haven't done them any service. And ultimately, we want to be of service to them and help them achieve what is meaningful to them.

**Steven Bruce**
Again, I don't know who's asked this question, but they're taking us back to I think a point that we sort of touched on earlier on is that how on earth do you get buy in for an in depth rehab programme when we actually find that we have trouble getting people to do a single exercise a day, let alone? Yeah, the goal setting help in that?

**Heather Watson**
Yes, because I think you're taking that time and it does take time and I appreciate that not every service depending where your work is set up. You feel you don't have this time and I I've worked in the NHS I've worked in first off the health department's of working in homelessness. Practice, I do understand those different pressures. But for me, if you want the buy in and you want a successful programme and you want a successful outcome for them and for you for your business, because you need to show that you're making a difference to people, then this is critical. Because if I set goals and I don't you know, when we, as long as the union chocolate similar for you, you taught how to, to write your patient's problem list and your goal list and it's very much your goal list. You know, the problem is they don't have full range of motion in their knee. Therefore, my goal is to get that full range of motion in their knee. But so what if they still can't latch on to school, they got full range of motion, but it hasn't translated into a meaningful activity to them. So I think this is key. And then linking your programmes if you then say, Well, I'm going to give you these exercises. I know they don't seem terribly interesting or exciting, but I'm only going to ask you to do them for one or two weeks because this is a stepping stone to that which is going to lead to your goal. In four

weeks time, that shows that you've listened you've heard and that you've got a plan that fits around their, their end goal, not your lovely sheet.

**Steven Bruce**
You stick to that rather hackneyed sort of acronym, the smart acronym for go approach to goals, you know, so that I can remember what the detail was. It's smart, measurable, probably achievable, realistic, and time limited. So this is the time limitation, isn't it?

**Heather Watson**
Yes, yeah. So we might have like, again, we're going to go into this in more detail. There's a little bit more in the E, but we've talked about primary goal. So the primary goal may well be the war, I want to walk my child to school, that takes me 20 minutes, I need to do it twice a day. That would be the primary goal. And then underneath that, you would have secondary goals. So the first thing might be well, at the moment, I can only walk for five minutes. So my first goal might be to walk for six minutes and then eight minutes and then for 10 and then 15 to 20. And so It's those sorts of things a primary goal, setting secondary goals, and then making your intervention, whatever it is relevant and say, Well, this is going to help us achieve that. Because in as much detail as the client wants to know, some people just want to be told, and then they go off and do it. Others want to really understand why, why that why now, why that many times.

**Steven Bruce**
More quick, more questions for you, Iqbal has asked whether a range of motion tests form part of your functional measurement,

**Heather Watson**
that range of motion test form part of our clinical examination. So we have that information going into the functional measurement, I would say range of motion itself does not necessarily tell us about the function. It's putting that information together which will fit really well with our next point, is putting that information together and saying if they lack range of motion, so let's take that knee and covered example, if they like range of motion in their left knee joint and That is what's preventing them completing that functional task of getting into that low level cupboard, then that becomes relevant and meaningful. And then we look at whether we can change the range of motion to facilitate the task, or are we stuck with that range of motion, therefore, we need to modify the task and how it's going to be achieved.

**Steven Bruce**
MCs asked a couple of questions. First of all, I think he's asking what you use to assess pain and emotion.

**Heather Watson**
And so we do we use a traditional visual analogue scale pain measure some ways within some of the other questions that we do have that we do a very detailed what we would term as a narrative or subjective assessment so very much invite the client to tell us about their experience and you know, the words that

they would use about their pain and their symptoms. So we take that into account and what was the second part of the question?

**Steven Bruce**
Sorry, I'll just moved on from that question. It was emotion rather than just promotion.

**Heather Watson**
Yeah. So yes, it was it was emotion. Yeah, I think emotion again, we will also through the questionnaires, what's lovely actually about some of the questionnaires, sometimes they give you a reason to dig a bit further. So they might answer something, especially in something like the rebo asked, Are you feeling anxious or depressed? And if they score quite highly, it kind of gives you permission to go asking a little bit more and say, Well, you know, can I ask, is that related to this condition? Or is there other things going on in your life that, you know, you might say some of you may don't you don't need to tell me about other things, but I just it would be helpful to know if this anxiety and feeling low is related to your injury and the impact it's having on your life or other other things happening that I just need to be aware of, um, you may of course become more aware of later down the line. So again, we are Pick it up from lots of different places, this inflammation

**Steven Bruce**
mix. other question is, is the case manager part of the insurance provider means one of their staff was simply paid for by them.

**Heather Watson**
It varies, that it varies a lot, a lot of insurance and all solicitors and appoint independent case management companies. And that's mainly who we work with. Some of them, the insurance, the big insurance have their own case managers. And there, we don't deal with many of those that that's probably not our direct market. If you are dealing with them, you'll be dealing with insurers employed, claims handlers and case managers and they will have their little panel of providers that they use and they probably deviate from it less. Whereas with the others would come to us because they're specialists, case managers, they're looking for specialist providers. They might come to us for one case, there was somebody totally different for different type of case.

**Steven Bruce**
Heather, we've reached point Five and we finally come on to rehab.

**Heather Watson**
Yeah, so this really, after we've gathered all that data, you can imagine now we've got a lot of data, we've got a lot of narrative information from the conversations we've had, we would have had a conversation about how our programmes are different from standard clinic based care. And that it may be it's time that they moved on from that. And that that, of course can bring people make great progress with that. So it's not a case of this is better, it may just be this is different. They need to understand that this is going to be

different. And this is why we're asking them a lot of information. So we've got narrative information. We've got patient reported outcome measures, we've got functional measures, and we've also now got goals that we've discussed. What we've got to do is bring all that information together, make sense of it between us, the client clinician and the client, and turn that into a plan and a programme that is going to cover Flexible but time limited period, because our programmes are time limited. We don't claim to have everybody fixed out the door in a certain timeframe, but we do limit the programme period so that a certain level of momentum is maintained maintain. So the rehab plan is produced from that all that data, okay, what are the priorities? What are the goals? What therefore do we need to work on first, in what order to make this happen? So if you've got someone who's highly fear avoidant of that, getting in and out of that kitchen cupboard, but we know that they've got sufficient range of motion with pretty sure they've got sufficient lower limb strength because they did a great system test. And actually, we know that this is about helping them tackle their fear and maybe their pain management. So we would prioritise that because we know if we unlock that key, the function will come the walking example That might simply be a lack of exercise tolerance, somebody lost their confidence especially now has not been out for months. And that what we need to do is put a progressive graded exposure graded time plan in for their walking. So we would plan that out over a month. No, we'll come this will check you getting on. Okay, we'll put it up next week to another two minutes or what have you. So this is about tailoring that information, creating a plan getting the buy in from the client that they want to do this and that they're up for it.

**Steven Bruce**
Okay, I'm not trying to hurry you along, but we're with four minutes left and one is progressing context.

**Heather Watson**
Oh, this is such a huge topic anyway. So I'm literally going to touch on it. This is about saying and I know this is difficult in a standard clinic environment. So I suppose this is about thinking beyond your clinic space. And think Can you take this person more into their contacts? Physically Can you do that? Because you might be able to you might just not have thought about doing it before. If you can't, though, have conversations about it, how are they going to transfer it into context? How can they take what you've been teaching them on supporting them with and transfer it into their context and come back to you and report it? So context examples, we had a guy who was a new amputee wanted to ride a motorbike again, our clinician took him to the high Davidson showroom with their permission by arrangement. They had a fabulous afternoon, trying and thinking about transferring his skills into the context of riding a motorbike and one of my earliest clients was a climbing instructor. I got him lined up with some lessons with an indoor climbing wall with an instructor who I knew was very good on communication and safety. And when they were happy, they then took that out and they did some climbing in the Peak District outdoors and I just went along to make sure they were okay. So it's about taking it that step further into the actual action. activity as early as you can.

**Steven Bruce**
Okay, and then your final point is measuring success, which I guess must differ from promise.

**Heather Watson**
So this is about going back and re measuring all those things, re measuring the problems, re measuring the functional tests, looking at those goals again and saying, have we achieved and obviously, you need to work out the beginning what success looks like for this client? Have we achieved what we said we were going to achieve with this programme? Have we achieved all of it, how we achieve part of it? If there are bits we didn't achieve? Were there? What were the reasons for that? And if that's something that needs to be addressed, separately, do we need a bit more programme we might go back and ask for more sessions. Have they reached a psychological obstacle that we can't overcome? And they really do need now something else is a bit different from us. So if you don't, if you bother taking these measures at the beginning, you really need to bother checking that you've reached them or not. And then of course, it also gives business data have we delivered on what we said we would deliver To our customer, do they want to buy from us again?

**Steven Bruce**
Yeah, it was a good point. I mean, what do you do with that? How do you make that make your successes known? Obviously, we're very constrained in what we certainly we osteopathic chiropractors are allowed to say in terms of advice. So who is taking the your feedback and saying, Oh, yeah, I can see that these people at your particular business are successful in what they're doing.

**Heather Watson**
Yeah, so a couple of things, though, we try and do case studies, not as we don't get them published as often as we'd like. But we do have a few. We collect our data. So we've got like, you know, a sample of data for that year, and then we're going to be doing the same. This last year of across the board, how many of our clients reach the goals that they'd set? And actually then also the report in the report that we do for an individual client that goes back to that case manager, they then got the before and after? How's this work for this client? Yes. Was it a positive experience for all concerned? Yes, they're more likely to refer another client to Because they're happy with how we've worked in the outcomes that we've able to demonstrate.

**Steven Bruce**
Now, we're at the end really, I put this bitly link up for people. If you're not familiar with Bitly links, if you just type that into your browser, it will take you to Heather's web page where you can download a free ebook, which summarises a lot of what we've been talking about today. Also, you probably weren't going to quite

**Heather Watson**
sign up to our email and we will send out the ebook because it's just being finalised.

**Steven Bruce**
So I mean, don't be worried about signing up to the emails because the Heather's using MailChimp. If ever you want to stop emails, you can either ask whether you can tell MailChimp to stop sending answers. Yes, it is a marketing thing. But of course, you know, it's just one way of delivering information that's useful to you in your own business. So don't be shy about it. So Bitly forward slash fr hyphen, e book, all lowercase.

That'll give you the chance to get some Heather's book, Heather. You got some courses coming up on rehab as well. I think I'm new

**Heather Watson**
here. We've got course it's brand new because it's brand new online format. We were going to take it that way. Anyway COVID is obviously forced us into that. I've got quite a long history along with my colleague Jane that works with me and designed to move of teaching this kind of stuff for the specialist interest group in occupational health physio. And we're basically get converted that into make it much more accessible to those of you who may just want to take this forward and experiment with it in your own practices. And how can you start applying these principles, there's going to be seven sessions starting mid October, and they will be live but also for those that sign up, you will also be able to access recordings if you can't make a session. And at some point in the future, we will convert that so that it's the kind of thing you could sign up and do online in your own time. But we're a little bit way off that so come to the live version.

**Steven Bruce**
Brilliant. Thank you. Look, I hope that's helped you in structuring your own rehab processes with your own patients, you may or may not be able to go into the same depth that Heather is doing. But you know, that's a very nice little seven step structure for you there. Have a I'm really grateful for you giving up your time and coming on here and best of luck with the courses that you're running. And hopefully lots of people signing up for the book as well.

**Heather Watson**
Yeah, it's been a real pleasure. Thank you very much for inviting me and I hope that's been helpful to your audience.

**Steven Bruce**
I'm sure it has. Thanks again.