Allied health professions supporting patient flow: a quick guide

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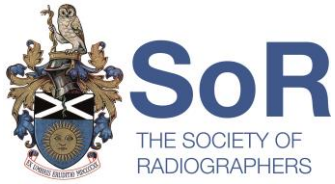

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Foreword

Delivering high quality, sustainable healthcare during a period of rising demand and austerity means that the contribution of allied health professionals (AHPs)[1] has never been so crucial. AHPs can significantly improve quality, effectiveness and productivity across care pathways. This document gives examples of how this can be done.

'Patient flow is a team sport'.[2] Without AHPs there would be no flow. Patients would languish in hospitals, inappropriate admissions would flood in and discharges would grind to a halt. AHPs, the third largest professional group in the NHS, are highly trained autonomous professionals whose collaborative work with medical, nursing and social care colleagues is the engine of patient flow.

AHPs into action (NHS England 2017)[3] is a 'call to action' for leaders and decision-makers to ensure that AHPs are involved in service development and improvement. It explores what AHPs can offer healthcare systems, including how they can support and provide solutions to demand growth in urgent and emergency care.

AHPs are now found working along the whole emergency care pathway, including:

- the community, keeping people safe and well at home
- at the 'front door' assessing, diagnosing and treating patients in emergency departments, ambulatory care and assessment units
- supporting avoidance of hospital admission
- enabling early rehabilitation and reducing overnight admissions
- driving Home First (discharge to assess) to avoid in-hospital deconditioning of frail, older people.

[1] www.england.nhs.uk/ahp/
[2] NHS Improvement: *Good practice guide: focus on improving patient flow*, 2017.
[3] www.england.nhs.uk/ahp/ahps-into-action/

Many solutions to apparently intractable problems lie with teamwork, and AHPs are at the core. This quick guide shows how NHS emergency care for adults can benefit from the effective use of AHPs and highlights opportunities for service redesign.

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1. Introduction

This quick guide demonstrates how NHS emergency care can benefit from the skills of allied health professionals (AHPs) and highlights innovative service redesign and the delivery of new care models. Each section gives a brief overview of the contribution AHPs can make to safe, effective patient care and flow, followed by case studies.

All the initiatives described in the case studies happened because motivated people had the vision to do something differently, to address a challenge or redesign a service to ensure the people they serve receive great care.

2. Keeping people safe and well at home

Proactive, timely and integrated care by AHPs can keep people with long-term conditions safe and well at home and avoid hospital admissions. Multiprofessional interventions include reablement, rehabilitation and promoting self-care. Service integration should include leisure, social care, the voluntary sector, community and primary care providers. The aim is to help people to maintain a high level of functioning, to keep them healthy and well for as long as possible in their own homes, and to support good end-of-life care at home.

Case Study 1: iCares – integrated community service

iCares is a seven-day integrated community service incorporating admission avoidance, care management and community rehabilitation services at Sandwell and West Birmingham Hospitals NHS Trust. The service is provided by a team of physiotherapists, occupational therapists, speech and language therapists, nurses and health assistants.

Any patient aged 16 years or over can be referred to the service. Following a clinical triage, a joint decision is made about the most appropriate service needs for the patient. The service can respond to urgent requests for assessment within three hours. Where an admission can be avoided the patient will be prioritised. Complex patients at risk of escalating to an urgent referral are seen within 72 hours. Access is through a single point and without criteria or referral barriers. Once embedded, iCares demonstrated how integrating locality teams, stratifying the population for risk and systematically implementing self-care and self-management significantly improved the quality and experience of care for patients.

Evaluation showed that iCares:

- reduced hospital admissions by 2,478 per year – 93% of patients who access the service stay in the community after an urgent visit rather than being admitted to hospital

- reduced length of stay in A&E
- reduced length of stay in hospital from 10 days to seven days
- reduced readmission
- helped the trust save nearly 17,000 bed days, which could reduce costs by over £7 million.

iCares works to prevent hospital admission by assessing and intervening early to support those who are at high risk of admission due to acute medical illness, such as urine infection, chest infection, flu, coughs, colds or cellulitis. These conditions lead to frailty and falls, resulting in less independence, swallowing problems, not eating and drinking enough and feeling unable to cope at home, as well as an increase in stress for both the patient and carers.

For further information see Case Study 26 in *AHPs into action*, NICE Shared Learning or contact: Sandwell.icares@nhs.net

Case Study 2: Frailty Assessment Base (FAB) team

The FAB team at Ipswich Hospital has shown that an integrated team operating within a clear framework and with clear objectives can improve patient experience, reduce admissions and increase the system's ability to manage frailty.

The FAB team consists of therapists, dietitians, pharmacists, specialist nurses and a specialist doctor. It receives referrals from GPs and the emergency department (ED). The team carries out a full assessment of frail patients and develops care plans. The aim is to help patients maintain their independence and remain at home whenever possible. Support includes lifestyle advice, medication reviews and linking with community teams or social support.

Evaluation showed:

- 80% of patients referred to the FAB team avoided admission, with more than 250 admissions avoided in six months
- 1,918 reduced bed days

- 100% of patients who use the service would recommend it
- 88% of patients assessed avoided immediate admission and were discharged to the community, with 58% returning home, a further 24% returning home with increased support and 6% transferring to an intermediate care bed
- 12% of patients required acute admission following assessment but had received a front-loaded geriatric assessment; their average length of stay was 1.35 days below the average for age-matched patients admitted through existing pathways
- 82% of staff involved in FAB across the system reported being satisfied with the quality of care given, with most also being happy to recommend working in the FAB team
- falls assessment waiting time reduced from three months to three days.

The service also aims to raise the awareness of frailty in the local healthcare community. Each patient is scored on the Rockwood Clinical Frailty Scale and this is communicated to GPs. System-wide efficiencies demonstrate that FAB supports best use of GP time with easy access. By offering a consultant telephone advice and triage service there are no waiting lists. Assessing patients before admission gives the opportunity to front load comprehensive geriatric assessment for those admitted, which saves time.

The downstream benefit has demonstrated reduced bed days and cost.

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Case Study 3: Surrey Heath Integrated Care Team

Surrey Heath Integrated Care Team (ICT) started operating under a single point of access (SPA) based in a GP practice in 2016, and has shown how working in an integrated way across organisational boundaries has reduced hospital and care home admissions in the region.

The service's main aim is to provide holistic person-centred care, to prevent hospital admission where appropriate and provide an in-reach service to help timely discharge as soon as the patient is fit. The team comprises nursing services (including specialist nurses), adult social care, community mental health for older people (65-plus and young-onset dementia), rapid response and rehabilitation (intermediate care), community rehabilitation, respiratory services and voluntary services. The team operates under a matrix management. The service operates a duty system, Monday to Friday, 8am to 8pm, with out-of-hours/crisis support services outside these core hours. There are three levels of response: two-hour for emergency/urgent referrals (hospital admission avoidance), 48-hour and routine.

During 2017/18, to date (February 2018) integrating services has shown:

- admissions to Frimley Park Hospital have reduced by 2% in Surrey Heath compared to a national average increase of 7% in 2017
- excess bed days have reduced by more than 1,000
- readmissions and attendance has reduced by 108
- admissions to care homes in Surrey Heath have reduced by 10.2% compared to the previous year.

Before the ICT, teams worked alone and so there were several referral routes. This resulted in several services receiving the same referrals, often duplicating effort and wasting time and resource because each team would respond to the referral in isolation. Since integration there is one point of contact where the referrer can have a conversation, if required, to ensure the most appropriate care professional responds in a timely manner to give the care required to keep the person safe and well at home.

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3. Avoiding admission to hospital

Many innovative schemes across the country have contributed to avoiding hospital admissions. Examples include primary care paramedics and occupational therapists and paramedic teams responding to non life-threatening calls (eg for falls and people with frailty). There are several effective models. Some use existing ambulance service infrastructure and some primary care to provide clinical and operational support.

These models deliver high quality interventions, and support care at home. They avoid traditional approaches that rely on transferring patients to hospital-based specialists.

Case Study 4: Early intervention vehicle

In East and North Hertfordshire, the early intervention vehicle (EIV) was launched with Vanguard funding during April 2016 as part of a whole-system approach to providing ‘right care in the right place at the right time’. It is a professional response vehicle provided by the ambulance service to promote falls prevention.

Typically, one in five 999 calls is for a patient who has suffered a fall. The EIV’s aim is to ensure patients in the community who have had a fall are medically and socially assessed quickly and, where appropriate, avoid being taken to hospital. The EIV is staffed by clinically trained emergency care practitioners from the ambulance service and county council staff who are physiotherapists, social workers or occupational therapists. The county council staff are responsible for ensuring patients referred to the service are assessed for risk of repeated falls. Where appropriate, referrals are expedited to the most appropriate services across the health and social care sector.

Since the EIV was introduced in April 2016, it has been has been dispatched to over 2,200 patients across east and north Hertfordshire. As a result:

- more than 70% of patients did not need to be taken to hospital

- admission avoidance over a year enabled 1,954 patients to be cared for in their own homes
- increased ambulance resources were freed to respond to life-threatening emergencies.

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Case Study 5: Paramedic home-visiting service in a general practice locality

South Central Ambulance Service NHS Foundation Trust developed this service using paramedics to release capacity while developing resilience and sustainability in primary care. It wanted to improve work-life balance in general practice, contribute to staff retention in primary and emergency care, provide opportunities for paramedic development and encourage the recycling of new knowledge back into paramedic practice.

The aim was to scope new working models across a system, rather than take a silo approach. A pilot took place in 2017. Two specialist practitioners were employed to provide a GP locality paramedic home-visiting service. Two vehicles equipped to 999 response level worked with six GP surgeries providing the home-visiting service following GP triage: patients were extremely unlikely to need an emergency hospital attendance that day.

Over 10 months, paramedics carried out 1,183 home visits, which released significant GP time to deal with urgent same-day demand. Key to success was the contact time between healthcare professionals, which built trust, improved collaboration and co-ordinated care for patients. Weekly mentorship with a named GP to discuss the previous week's patients improved the paramedic workforce's skills and knowledge.

While the project's overarching aim was not specifically to prevent avoidable hospital admission, it shows how using multiprofessional skills can offer a timely response to ill health. Responding to immediate health needs and preventing further deterioration helps people to remain well in their own home. Evaluation found:

- 93% of patients assessed did not require an emergency hospital attendance
- 96% of visits did not require any further GP appointments.

Key learning points were:

- vehicles fully equipped to emergency standards were not needed for this role.
- patients accepted an alternative healthcare professional visiting.
- the option to call back and/or review a patient later creates admission avoidance opportunities.
- building a trusting relationship between healthcare professionals is pivotal to efficiency.
- digital photography contributed significantly to efficiency and safety.

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4. Allied health professionals in the emergency department

The growing number and complexity of patients attending emergency departments has created a need to strengthen and broaden the workforce to increase its resilience and effectiveness. AHPs offer a range of skills that are well suited to supporting ED teams to manage their increasingly complex casemix.

AHPs in ED use expert knowledge and skills to improve patient care and flow, and prevent hospital admissions. Intervening early in the pathway ensures a focus on restoring function and supporting independence, enabling timely discharge, avoidable admission or shortened length of stay (LOS). Examples of innovative practice emerging demonstrate the impact of the unique skillset these professionals bring to the multidisciplinary team including additional skills from advanced clinical practice.

Advanced clinical practice

A new national framework has been established to enable the further development of multiprofessional advanced clinical practice (NHS Improvement, NHS England and Health Education England 2017). The framework includes for the first time a national definition and standards for the multiprofessional advanced level of practice.

Advanced clinical practice is characterised by a high level of autonomy and complex decision-making. It is underpinned by a Masters-level award or equivalent that encompasses clinical practice, management and leadership, education and research, and core and area-specific clinical competencies.

Case study 6: Emergency physiotherapy practitioners

Musculoskeletal emergency physiotherapy practitioners (EPPs) work as frontline healthcare providers for patients who attend emergency departments, managing those who attend with musculoskeletal dysfunction. Integrating EPPs in ED improves patient outcomes and patient flow, streamlines care without additional radiographic investigation, reduces costs and improves patient satisfaction.

An initial pilot at Queen's Hospital, part of Burton Hospitals NHS Foundation Trust, established a musculoskeletal EPP service in ED from 2013. Since then, three EPPs have worked in ED, all senior physiotherapists with advanced practice skills in emergency care. Patients are assessed and diagnosed without the need for medical or nursing intervention. EPPs are able to refer patients for investigations to assist diagnosis, such as X-rays and blood tests. Local data has shown that incorporating EPPs in ED reduces waiting times for patients with musculoskeletal problems:

- the median wait time for treatment by an EPP was 34.5 minutes, 20 minutes less than national median wait times
- after EPP intervention, 3% of patients returned to ED following discharge, compared to 7.5% nationally. Outcome analysis shows that reducing avoidable reattendances in ED by improving care and communication during a first attendance is a key indicator of effective clinical intervention. To represent good practice, unplanned reattendance rates should be less than 5%. EPPs in ED at Queen's Hospital have shown this can be achieved.

Now that EPPs see many of the patients with musculoskeletal problems, more medical and nursing time is available to manage other patients attending ED.

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Case Study 7: Seven-day ED discharge assessment service

The AHP discharge assessment service at Royal United Hospitals Bath NHS Foundation Trust was launched in 2016. Its aim was to avoid hospital admissions from ED for patients assessed as medically fit to return home. The team developed a seven-day therapy-led service in ED, consisting of physiotherapists and occupational therapists. The team developed interprofessional standards for all referrals.

Evaluation during 2016/17 showed that 2,046 patients were assessed, 1,340 from ED and 706 from the medical assessment unit (MAU); 64% were discharged home the same day, avoiding hospital admission. All professional standards set were exceeded. Patients referred from 'majors' were reviewed and assessed on average within 15 minutes. Patients referred from 'minors' were reviewed and assessed on average within 21 minutes. An analysis of outcome showed most patients referred and assessed presented to ED following a fall.

The success of this type of service depends on maintaining strong links and relationships with community colleagues to ensure the continued flow of patients discharged from ED into primary care.

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Case Study 8: Frailty functional assessment service

The frailty functional assessment service at Stepping Hill Hospital, Stockport NHS Foundation Trust, is a therapy-led service based in ED.

A physiotherapist and occupational therapist are based in ED seven days a week from 8am to 4.30pm. They work with paramedics to obtain a 'FRESH' handover (functional, risks, equipment, support, home environment) and to screen and assess frail, older patients using a Rockwood clinical frailty scale. The service has shown that an early, 'front-door' therapy assessment is needed to enable proactive, person-centred care and discharge planning. Early engagement with the patient and their families/carers is essential to ensure early mobilisation to prevent deconditioning, establish a plan to avoid admission or a prolonged length of stay (LOS) and to manage expectations.

The service works closely with Age UK and the community crisis response team to ensure ongoing care needs are addressed in the person's home and signposting to other preventive services, such as exercise prescription, the 'Community Steady' service in Stockport and community therapy teams.

Evaluation showed:

- 80% of patients are seen within four hours
- 42% of patients seen by the team go home, avoiding admission
- a one-day reduction of inpatient LOS (in the study group) compared to the previous year's data.

Lessons learned:

- for the service to be successful its aims must be communicated clearly to everyone involved
- therapists in ED need to be confident and assertive to challenge historic behaviours and cultures and unlock AHPs' potential to improve front-door services.

For further information please contact: Stephanie.brown@stockport.nhs.uk

Case Study 9: Atraumatic back pain pathway in ED

Salford Royal Hospital introduced an atraumatic back pain pathway pilot in 2014. The aim was to assess whether consultant physiotherapists can effectively manage non-surgical complex back pain in ED. The service is now part of 'business as usual'.

Close links exist with spinal surgeons to enable direct referrals. Connections with community musculoskeletal services allow integrated outpatient management. This helps prevent repeated ED attendances and enables early supported discharge with primary care follow-up.

Patients requiring overnight admission are admitted under the care of emergency medicine and referred the following morning to the spinal physiotherapy team. As

well as supporting ED, a consultant physiotherapist from the team reviews ward patients to ensure that evidence-based treatment is provided.

The service has transformed care for patients with back pain. Previously, they were admitted under the care of emergency physicians, with no direct access to outpatient services and great difficulty in obtaining input from spinal specialists. Now patients are seen by consultant physiotherapists who are experts in the field, often on the day of their initial attendance.

Evaluation indicates:

- length of stay for these patients shortened from 4.44 days to 1.04 days compared with the previous three years, a reduction of 76.6%
- the number of admissions fell from 821.5 to 556.3 per year
- in a survey of consultants in ED, acute medicine and spinal surgery, and senior nurses in ED and the emergency admissions unit, all agreed the pathway benefits patient care.

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5. Radiographers in the emergency department

The role of radiographers supporting ED has changed significantly over the last decade with the development of advanced practice roles across most imaging modalities. Radiographers now report CT head scans to support rapid stroke assessment, musculoskeletal images to enable patients with normal X-rays to be discharged, and chest X-rays to support clinical decision-making and patient safety.

The following case studies give two examples of services delivered in an innovative way to support urgent and emergency care.

Case Study 10: Radiography 'hot' reporting service

At City Hospitals Sunderland NHS Foundation Trust, the largest group of litigation claims against ED and urgent care services were caused by interpretive errors on radiographs. In response to Sign up to Safety's launch in 2014 by NHS England, the NHS Litigation Authority committed to help reduce avoidable harm by 50%.

City Hospitals' radiography team developed a radiographer-led remote 'hot' reporting service to improve patients' safety and care when attending ED and urgent care centres. The service operates 14 hours a day, seven days a week, increasing provision from 37.5 to 78 hours. This was achieved by installing reporting workstations in reporting radiographer's homes. To comply with information governance standards, access to the service was granted only by a secure virtual private network. New standard operating procedures were written for the department, to meet information governance, security and reporting standards.

To measure the service's effectiveness, the number of 'missed fractures' was measured before and after the scheme was introduced. Missed fracture claims reduced by 66% from 1.24% of litigation costs for ED to 0.42%. Analysis showed most of the remaining missed fractures occurred when the hot reporting service was not open.

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Case Study 11: Radiography discharge service

Building on the success of hot reporting by radiographers, Northumbria Healthcare NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust introduced a radiographer discharge service to improve patient flow at the back door.

Radiographers undertook additional training to manage the discharge process, including advising on injury management for patients with normal X-ray findings. Different models were used for training – in-house for advanced practitioners (reporting radiographers) at one site; at another, attendance at a local emergency nurse practitioner course for band 6 radiographers or advanced practitioners. Appropriate governance systems were established, including responsibility for record keeping and data management on the ED system.

After a normal X-ray, patients are given information on the diagnosis and management of their soft tissue injuries under protocol and are discharged home without reattending the emergency department. This has been shown to release ED capacity by reducing patient interactions, improves patient experience and reduces waiting times while maintaining continuity of care. Engagement of ED staff is key to maintaining confidence in service quality.

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Case Study 12: Acute ultrasound provision

Ultrasound service provision at Northumbria Healthcare NHS Foundation Trust has changed dramatically over the last two years with the centralisation of emergency care at the Northumbria Specialist Emergency Care Hospital (NSECH).

A sonographer (radiographers specialising in ultrasound) led emergency ultrasound service was traditionally provided at both North Tyneside General Hospital and Wansbeck Hospital between 9am and 5pm, seven days a week, 365 days a year. Now all acute and emergency ultrasound is carried out at NSECH, and the service provides cover from 8am until 8pm, seven days a week, 365 days a year.

Ultrasound reports are provided immediately after a scan is completed, and a plan is in progress to alter the patient pathway for even better access to the ultrasound service directly from the patient's bed on A&E.

Comparing the time from request to report for all emergency care, ambulatory care and surgical assessment unit patients made between 8am and 8pm and completed within 24 hours demonstrates a marked improvement:

- January to May 2015 – 547 of 843 (64.9%) – average of 8 hours 53 minutes
- January to May 2016 – 2,117 of 2,696 (78.5%) – average of 2 hours 33 minutes.

A clear contributing factor is an enhanced, flexible and on-site ultrasound service.

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6. Home First

Home First (or ‘discharge to assess’) is a joint health and social care response that enables patients to be discharged home from hospital as soon as they are medically fit. The aim is to provide responsive, person-centred services for recovery and reablement at home.

Case finding for discharge to assess pathways is most effective when it starts at the front door. Occupational therapists and physiotherapists are expert in functional assessment and therefore well suited to this role. Early intervention enables seamless working with the multidisciplinary team towards discharge without sequential assessments later down the pathway.

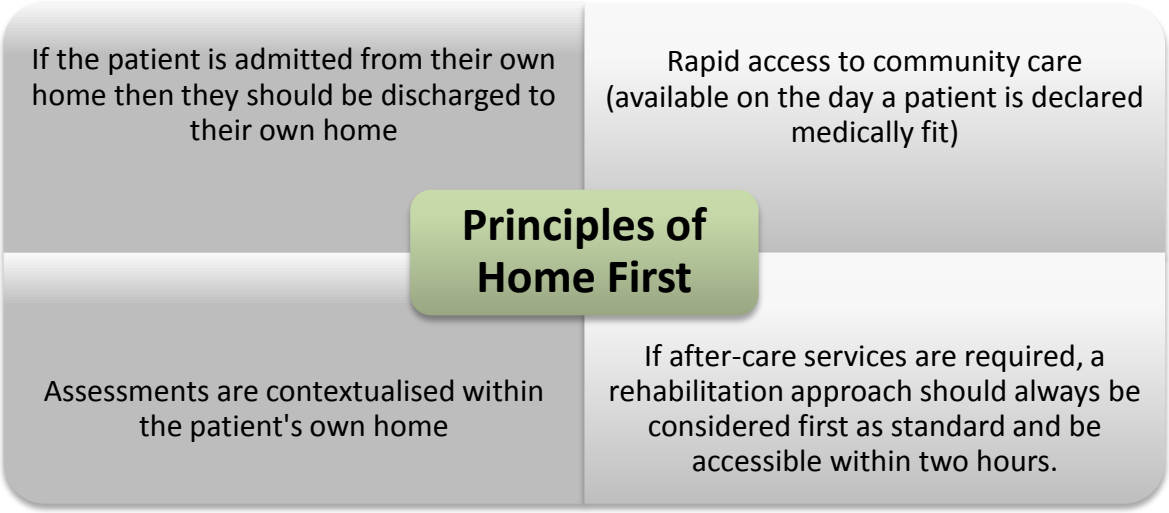
Home First requires new mindsets and skills. Acute therapists need to be able to work effectively at the interface between acute and community services, and to understand what community services (both care and therapy) can offer. A step away from traditional goal-setting within the acute environment is needed. Therapists must view all their patients as having potential to functionally improve once discharged from hospital. This precludes long-term care decisions being made in hospital. With Home First, assessment begins once the person returns to their home and not in an artificial hospital environment that may mask their potential.

Case Study 13: Home First in East Lancashire

East Lancashire Hospitals NHS Trust set out to prevent the problems associated with deconditioning in hospital by supporting people to return home quickly. Patients, families and carers are fully involved in assessment and care planning.

The approach is underpinned by the four principles shown in the Figure below.

Figure: Four principles of Home First in East Lancashire



The local clinical commissioning group, local authority and acute hospital co-designed the service with patients. A multiprofessional team works across organisational boundaries, and trusted assessment is embedded across a number of services. There is a single homecare provider and the service has rapid access to several health and social care support services.

The team carries out an initial assessment in the patient's home to understand what support is needed. The person receiving the service has a single contact point and is reviewed after the first three days.

Outcome data shows:

- 38% of people need no further input from any service after five days
- 51% are transferred to a reablement pathway
- 14% did not need, or initially declined, social care input, but after returning home found they did need it; these people may have been readmitted as a failed discharge if the team had not reviewed their needs.

The service is being expanded to take more people home.

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Case Study 14: Integrated rehabilitation and reablement service

The London Borough of Havering (LBH) and Barking, Havering and Redbridge University Hospitals NHS Foundation Trust reviewed 'out of hospital' pathways as part of their intermediate care programme and found:

- rehabilitation and reablement services overlapped.
- two separate referral routes into services.
- duplication in referral, assessment, care planning and review.
- up to 72 hours' wait for a person to be discharged.

LBH recommissioned its reablement service for a more integrated approach with rehabilitation. The aims were to simplify the pathway, decrease duplication between the two services and to be timely in responding to discharge. Three crucial changes were made to:

1. The referral process
   - no social care assessments to be carried out in hospital
   - the therapy discharge documentation was reviewed and revised
   - therapists to refer directly to the reablement/rehabilitation service using a one-page therapy discharge report, combined with an initial assessment
   - the provider to carry out the assessment in the patient's home within 24 to 48 hours in line with Home First principles
   - if patients require both rehabilitation and reablement, this can be referred at the same time and will have one assessment.

2. The initial interview in the hospital
   - paperwork reviewed across nursing, community and inpatient therapy teams
   - following meetings with staff from each team, a single assessment was agreed – the 'initial interview'
   - rapid tests of change (plan-do-study-act cycles) held each month to review effectiveness and refine the assessment based on people's experience of using it.

3. The discharge report
   - was reviewed and revised to be clear, concise and more user-friendly
   - any information already on the initial interview was removed
   - standardised discharge recommendations/options
   - enables carers to provide support immediately based on information provided
   - therapy-led referrals rather than social worker assessment in hospital.

Outcomes are:

- 67% of people do not require further care at the end of reablement (increased from 48%)
- of the people who do require further care, 66% need fewer care hours
- the number of patients who return to adult social care and require an ongoing service within 91 days reduced from 5.8% to 3.9% in 2016/17
- residential care admissions from hospital reduced
- better quality of care for the patient – they are asked for their social information once only
- improved joint working across teams
- support for the development of the enhanced therapy role
- now forms part of the comprehensive geriatric assessment
- less time to discharge patients
- duplication of assessment and care planning has been removed.

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7. Therapy-led units

Therapy-led units may benefit patients who are medically fit for discharge but require further physical, psychological or social support to regain or maintain their skills, confidence and independence. They require an environment that promotes a philosophy of self-care and self-management, supports wellbeing, and maintains functional capacity.

Case Study 15: Castle Brook Transitional Unit

The therapy-led Castle Brook Transitional Unit was established by South Warwickshire NHS Foundation Trust and Warwickshire Care Services. The unit's purpose is to manage 'medically fit' patients who need support at night or between care calls but no longer require medical treatment provided by an acute ward. These patients are assessed as not yet able to manage at home.

The unit's overall aims are to:

- increase independence and daily living skills
- avoid the loss of confidence or ability associated with spending too long in hospital
- reduce unnecessary hospital delays; once a person is medically fit they should be discharged as soon as possible with sufficient support to meet their short-term needs
- reduce costly long-term health and social care provision where people can be safely supported with less intervention in their lives
- ensure people receive a period of recovery away from the acute hospital to enable an accurate assessment of their health and social care needs
- make sure patients are supported to return home if possible, or in a homely setting whenever appropriate, for as long as possible

- make sure that decisions about long-term support are made out of hospital and ensure, if appropriate, that people have access to therapeutic and reablement services to reach their optimum potential.

At Castle Brook, there are daily handovers that enhance integration and communications between acute and community service teams. A weekly multidisciplinary team meeting is attended by a social worker and Age UK representative. Three times a week, GPs visit patients who may require medical intervention.

Technology has helped speed up admission processes. A trusted assessment is completed online by the therapy lead, with baseline information and care plans created for the patient. This is sent electronically to the care duty managers in the unit, which avoids care home staff having to visit the patient on the ward.

Having the unit based in a care home allows a less institutionalised and more therapy-enriched environment. This promotes the successful transition of patients from the acute hospital to the community and to their normal place of residence. Patients receive both one-to-one and group therapy sessions, and are encouraged to recreate their normal home routines.

Average length of stay is 14.3 days. The service:

- saved 1,870 hospital bed days between April and October 2017
- discharged 89% of patients to their usual place of residence (9% were readmitted to hospital and 2% discharged to a care home)
- returned 83% of patients home self-medicating
- reduced patient night-needs on discharge by 96%
- achieved 100% of patients agreeing they would be likely to recommend the service to family and friends (September 2017)
- improved all patients in at least one aspect of the therapy outcome measure
- improved the elderly mobility score for 93% of patients.

For further information please contact: sheryl.johnson@swft.nhs.uk

For further case studies on therapy-led units: www.england.nhs.uk/leadingchange/staff-leadership/framework-to-support-winter-pressures-2017-18/

8. Recommendations for action

'AHPs can lead change' is the first of four priorities in the national *AHPs into action* strategy and is essential to meet the challenges of changing care needs. It gives permission to AHPs to propose and lead change regardless of role, organisation or level of decision-making. Leadership is crucial to enabling the changes described in this document to deliver the impact required for system sustainability.

Sustainability and transformation partnership/integrated care system leads, commissioners and providers should:

- engage local AHP leaders to identify opportunities for improvements to flow along the whole emergency care pathway
- work with AHPs to identify 'quick wins' for supporting emergency pressures
- involve AHPs in longer-term planning for redesigning urgent and emergency care pathways.

Directors/deputy directors of AHPs/therapies should strategically lead transformational change to ensure AHPs are in the right place, at the right time, with the right skills to lead change and support patient flow.

All AHPs should:

- ask what they need to start, stop or do differently to support patient flow across the system and to gain the most value from AHPs skills
- review the 10 clinical standards of the seven day hospital services programme (NHS England, Seven Day Services Clinical Standards, 2017) to ensure AHP services support the ambition for patients, admitted as an emergency, to receive high quality consistent care, whatever day they enter hospital

- use the ‘state of readiness for future care’ framework (see Annex) to review utilisation of the workforce:
  - are all professions working at the top of their scope of practice?
  - what skills are or can be shared to reduce duplication and silo working?
  - what can we train others to do and safely delegate?
- support cultural change, particularly moving from risk aversion to a culture of embracing positive risk as part of AHPs’ professional duties (Royal College of Occupational Therapists 2018)
- evaluate, improve and demonstrate the impact of AHPs’ contribution (Priority 3, *AHPs into action*)
- ensure that AHPs are aware of, support and where appropriate, lead initiatives such as the SAFER patient flow bundle, Red2Green days, ‘end PJ paralysis’ and ‘last 1000 days’ campaigns, recognising the value of their input.

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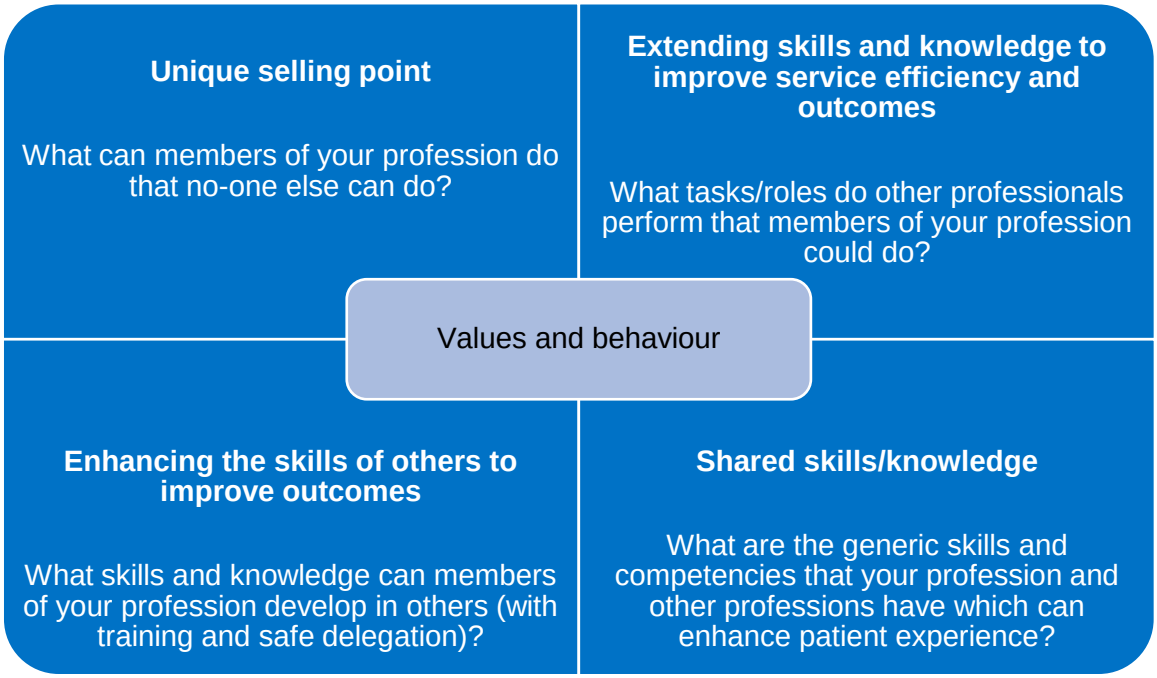
Annex: State of readiness for future care



Source: *AHPs into action: using allied health professionals to transform health, care and wellbeing* (2017), page 43.

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