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NHS Foundation Trust

New Workforce Models – Keeping You Informed Edition 18

Your Guide to SWeET
Strategic Workforce Education and Training

This edition of the 'Keeping You Informed' bulletin focusses on the formation of the Acute Care Therapy Team and how they're working to reduce unnecessary admissions.

Head of Therapy Services, Lucy Smith

In June 2018 an exciting opportunity was presented to me as Head of Therapy Services to submit an expression of interest to be involved with a national NHSI collaborative on how Allied Health Professions (AHPs) can support patient flow. Significant progress has been made over recent years to increase the contribution of the AHPs at CRH. However, there was a strong sense that their contribution to improving patient flow was not optimal, and that more could be done to exploit the skills and knowledge of the constituent professions to improve patient's experience and increase the productivity of the hospital. In light of this, the launch of the NHSI collaborative was seen as an ideal opportunity to focus attention on this issue, and to provide a stimulus to innovation and the re-design of care pathways through the expanded contribution of AHP led care.

Following selection to participate in the collaborative, the project team was established. This included colleagues from Acute Medicine, Adult Social Care, DCHS community therapy team as well as the therapy services, with the important engagement from our patients and their families.

The team agreed the focus for the project was to reduce avoidable admissions to Chesterfield Royal Hospital. This would be achieved by integrating AHPs & social workers into ED to proactively assess patients and, where appropriate, adopt a #homefirst mentality to support the safe return to their homes instead of being inappropriately admitted into hospital.

It was anticipated that moving ACTT to be based within ED would significantly increase their workload (which it did ☺). By adopting a more holistic approach and shared skills between the Physiotherapists and Occupational Therapists, the pathways were streamlined, reducing duplication of assessments making the service not only more efficient but improving the quality of the service to patients and avoiding repetition.

This project demonstrates how looking at new ways of working and workforce models can impact on the quality of care that is delivered whilst providing a positive experience for our patients and their families. This project would not have been possible without the successful collaboration across all the services and teams who came together to succeed with a common goal in mind, #homefirst. It is important to ensure that people are in hospital for the shortest possible time ensuring that medical and nursing needs that can only be delivered in an acute hospital setting happen there. All lower level care, recovery, rehabilitation and re-ablement should wherever possible happen in the person's usual place of residence – 10 days in hospital leads to the equivalent of 20 years muscle ageing in the muscles of people over 80.

I want to say a massive thank you to everyone who was involved as the initial results are extremely positive and all the hard work is achieving what the project set out to do. I am excited to see how this evolves as the team continue to strive to further develop these roles, link closely with other AHP colleagues and the wider MDT along the frailty pathway and sharing this holistic approach hopefully across other pathways. We have had so many positive comments from patients which I think says it all about how the service has been received.

The Acute Care Therapy Team

The Acute Care Therapy Team (ACTT), previously known as the Admission Avoidance Team, has been 'live' since 17th September 2018; our team consists of Occupational Therapists, Physiotherapists, Technical Instructors and Assistants, with the shared aim of facilitating a safe discharge of patients seen within our Emergency Department, Emergency Management Unit, Short Stay Unit and the Frailty Unit; either to their home or to an alternative environment as soon as possible, with the appropriate support systems in place.

An assessment is required from a member or members of the team, to determine if a patient is suitable to return to home, with the #homefirst approach and how well they are likely to manage with daily needs within this environment. We acknowledged a need for a shared skills base, with the development of shared competencies between professions to allow for a more streamlined approach to patient assessments. This reduces the number of assessments per patient and thus improves patient flow; along with the quality of patient experience on their journey, towards discharge.

ACTT is part of a wider multidisciplinary team of allocated social workers, local community Therapy teams, nursing teams and consultants; all aiming to reduce avoidable hospital admissions and promote safe discharges. By sharing competencies we can support patients and colleagues during assessments, to establish a patient's needs with a reduced number of interventions, increasing the capacity of the team.

Prior to this, the patient was generally assessed by the physiotherapist and occupational therapist with the patient referred by the nursing and medical teams. Our new process of working is proactive and promotes screening of patients as opposed to waiting for a referral, to support patients as early as possible.

As a team, we now have a base within the Emergency Department, providing the team with access to the EDIS system, to continually observe and assess the live system within the department. Along with this, our assessments follow patients on their journey throughout the hospital, such as to the Emergency Management Unit or Short Stay Unit. If a patient is admitted to other wards we liaise with the relevant therapy teams with the aim of reducing the onward number of therapy assessments required, continuing to improve patient flow and giving a high quality patient experience.

Statistically, within the first month 358 patients were assessed by ACTT and 65% (233 patients) were discharged home. 85 of these patients were discharged directly from the Emergency Department. There was an 80% increase in patients assessed within ED, a 60% increase in patients assessed on the emergency medical unit and due to this earlier intervention a 40% reduction in patients assessed on the short stay ward.

The results also show that the total hospital readmissions and the length of stay on the Frailty Unit are at the lowest rate since January 2018 for this group of patients where the ACTT are specifically involved with their care. This new way of working enables the team to see more patients, more effectively with fewer unnecessary hospital admissions and a reduced length of stay on our short stay facilities.

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