North West Allied Health Professions Network
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NHS
Health Education North West

CASE STUDY: AHPs working differently.

Aintree At Home Team

Aintree University Hospital NHS Trust

Summary: The introduction of the Aintree at Home (A@H) Community Therapy led Service in December 2012 was in response the Trust needing to increase the number of medical discharges. This was achieved by facilitating more timely and effective safe discharges and contributing to an improved patient experience by providing continuation of their functional rehabilitation and short term care support in their own/family home. This new model presented an innovative solution to supporting bed capacity management at Aintree.

Key Themes:

- Innovation
- 7 day working
- Integration

Which AHPs are involved?

- Physiotherapists
- Occupational Therapists
- Therapy Assistants

Objectives of A@H:

- Improve utilisation of acute beds, having the right patient in the right bed.
- Discharge patients home sooner saving bed days.
- Reduce length of stay due to delays waiting for POC to start.
- Reduce delays in access, fitting and assessment of equipment necessary for safe living at home.
- Increase staff, patient and family confidence to discharge.
- Complete more assessments in the patient's own home, rather than in hospital.
- Minimise the risk of re admission within 72 hours post discharge and/or represent at the Emergency Department.
- Seamless discharge of our patients and improve out patient's care and experience.
- Reduce number of complaints the hospital receives around discharge by improving discharge processes and multidisciplinary team working.
- Improve patient experience and satisfaction with discharge process.
- Maintain the functional ability of patients and to reduce de-conditioning of patients while waiting for community services.

Outcome Measures:

- Bed days saved.
- Service delivered.
- Prevention of Re-admission & risks/ themes.
- Number of same day visits.
- Total number of A@H visits/ patient.

- Locality of patient (Liverpool, Sefton, Knowsley, Other).
- Ward of patient (indicates speciality).
- Patient satisfaction.
- Staff satisfaction.

What setting does the service operate in? Based in acute hospital, the team out-reach into patients own homes on discharge for up to 3-7 days.

Does the service work with Older People? Any patients over 18 years are accepted, although the majority of patients are frail older people.

How did you identify the changes that needed to take place? Analysis of what kept patients in hospital despite them being deemed as medically fit.

When did you start making the change & how long did it take? In reality, little lead time. The service started with 2 members of existing staff who expressed an interest. Systems and documentation etc. were developed as we went along, as the Trust wanted the service up and running ASAP!!

How did you go about making the change? Quickly!!

How was the change funded? Initially commissioned by Liverpool CCG in the pilot stage; now totally funded from within Aintree.

Who was involved in the consultation and process of change?

- Senior Trust and therapy management, including CEO.
- In patient Therapists
- Community therapists.
- Medical Social Worker's and patient flow/ discharge planners.
- Commissioners, GP locality.
- Medical staff.
- Pharmacy.
- Discharge lounge.
- All wards.

What communication strategies were used to engage people in the change?

- Lots of presentations to all of the above.
- Advertisement within Aintree News and weekly Therapy briefing communication documents.
- Attending team meetings for face to face discussion.
- Posters.

Were changes needed to the existing skill mix? Additional staff of all grades B2-7

Were any new roles developed? Yes more generic working and utilisation of existing competencies for occupational and physiotherapy assistants.

What have been the benefits?

Achieving person-centred care:

- Assessments in the hospital don't always identify the needs of the patient at home; we achieve 66% same day of discharge visits which creates smooth discharge of our patients and improve their care & experience.
- Patients are most at risk within 72 hours post discharge to re-present at the Emergency Department and some re-admissions could have been prevented with minimal intervention at home.
- The majority of complaints the hospital receive are around discharge: A@H team frequently resolve issues patients and families have post discharge.

Finance: Over the last 12 months A@H has saved over 2000 bed days and prevented over 300 re-admissions.

Other:

- Moving towards the "Discharge to Assess" Model.
- Deliver more timely & relevant interventions via problem solving at home including sign posting.
- Timely provision & assessment of necessary equipment in their home; improves patient safety, provides re assurance & promotes independence at home.
- Reduce re admission rates; reduce pressure on A&E, in-patient beds.
- Staff education; feedback to discharging teams.
- Changing current ways of working and culture.
- Staff satisfaction.
- Improved working relationships within different teams within therapy, within organisation and external (community services, NHS and voluntary).

What has been the response to change?

100% positive evaluation.

7-day working

What are your agreed staffing levels and how do you calculate them?

Current Establishment:

- 15 Qualified staff (B5-7) Occupational therapists, physiotherapists, RGN's.
- 10 Un registered staff (B2-3).

Has demand increased as a result of implementing 7 day working?

Yes, we are able to support more patients home earlier as able to provide care and support over the week end.

Do you have full staffing on all days?

Slightly reduced level of service at weekends.

Cover arrangements for annual, maternity and study leave etc.

None, covered within team.

How did you agree on the minimum staffing level?

Based on staffing levels and 7 day rota.

Integration

Do you work in integrated teams? Yes.

Has there been the impact on the uni-professional role?

Yes as staff give care and treatment based more on patient need, rather than their own professional background. The aim is to reduce hand off's within the team; the therapist and/or nurse with the most relevant background will see the patient.

Are team members involved in any generic working - and what training or support is available for this?

Yes, completion of relevant competencies, regular supervision, local training sessions, on the job training.

What difficulties did you face?

- Initially there was some reluctance from therapy and medical staff to embrace the concept of "earlier" discharge: fear of unsafe discharges, delays in access to follow up services, lack of understanding of therapy role within the care package element (re enablement agenda) and feeling of loss of role.
- Problem solving in the patients home, especially non therapy issues, such as patients' condition deteriorating, medication issues, care package changes required.

What have you learnt from this process?

- Get the right staff (flexible, patient focused).
- Identify & engage early with your stake holders: e.g. Commissioners, MSW.
- Develop strong partnerships with Therapy staff/ Patient Flow/ discharge co-ordinators/ District Nurses/ GP's.
- Feedback to in-patient clinical teams on issues (positive & negative).
- Robust IT infrastructure to prove the benefit.
- Communication ++++ key to success.
- Patient experience VERY powerful tool (quotes, video, case studies).
- Keep a high Profile:
    - Locally - posters, leaflets, Aintree News, meetings, training sessions, presentations galore!!
    - Nationally: poster presentations ECIST, AHP Conference.
- Establishment of B5 Physiotherapy & Occupational therapy rotational posts through A@H team will assist in education and promote new ways of working.
- Celebrate achievements: Excellence awards/ Frontline/OT News.
- Proving the benefits to patients and the Trust ASAP and communicating that.
- Utilising early adopters to help others embrace the new way of working.

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Information collected via self-completed template.

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