Enhancing Clinical Care Framework for Care Homes (ECCF) Workforce Subgroup

-Models of Allied Health Professions (AHP) Input to Care Homes

Evaluation of models of Allied Health Professions (AHP) input to care homes in Northern Ireland and recommendations to ECCF for future delivery of AHP service

Report from AHP Models of Input to Care Homes Task and Finish Group of Workforce Subgroup

Final-30 November 2022

1. Context

This report was developed by the Allied Health Professions (AHP) Models of Input to Care Homes Task and Finish group of the Enhancing Clinical Care Framework for Care Homes (ECCF) Project Workforce subgroup. This task and finish group, with membership outlined in Appendix 1, was multidisciplinary and established as part of the ECCF Workforce subgroup to evaluate if the needs of residents are being met by the models of AHP input to care homes in Northern Ireland and make recommendations for improvement.

"On 17 June 2020, the Minister announced plans for the Chief Nursing Officer for Northern Ireland, Professor Charlotte McArdle, to coproduce a new framework for enhancing clinical care for residents in care homes, working in partnership with the Independent Sector. The aim of the Enhancing Clinical Care Framework (ECCF) project is to ensure that people who live in care homes are supported to lead the best life possible" and have access to equitable healthcare provision (DoH,2021). "The outcome is the coproduction of a framework to enable continuing safe, high quality and person-centred clinical care within care homes." (DoH, 2021)

"The Project is one of the ten Key Actions under the No More Silos Action Plan which aims to develop an enhanced range of safer and more effective elective and unscheduled care services" (DoH 2021). The Review of Urgent and Emergency Care Services in Northern Ireland which continues the strategic direction set out in the No More Silos Action Plan and the Intermediate Care Project (DoH, 2022a) describes the Care Home Support Teams here and "the premise of pro-active support and education in-reach to Care Homes is consistent throughout"

ECCF documents state that "There are 483 registered independent nursing and residential homes in Northern Ireland; 235 residential facilities and 248 nursing home facilities. In total the sector has 16,000 beds; this compares with an estimated 6,000 hospital beds in the Health and Social Care (HSC) acute sector. 99% of nursing care beds (10.5k) are provided in the independent sector and 80% of residential care homes beds (5.5k)". Key documents for this project are listed here.

2. Introduction

The AHP Models of Input to Care Homes task and finish group was set up as part of the ECCF Workforce subgroup as it was recognised within this subgroup that AHPs are an essential element of the workforce required to meet the needs of care home residents, with a key project deliverable being "Enhanced AHP support model for nursing homes" (DoH, 2021). The broad range of Allied Health Professions work across all age groups and specialities and are comprised of Arts therapy, Dietetics, Occupational therapy, Orthoptics, Paramedics, Physiotherapy, Podiatry, Prosthetics, Radiography, Dramatherapy, Music therapy, Orthotics (DoH, 2022b)

The purpose of the task and finish group was to evaluate the models across Northern Ireland for AHP input to care homes and to make recommendations to the ECCF Workforce subgroup on the preferred model of AHP input. The task and finish group focused investigation on five of the AHP professions which typically receive referrals for care home residents, namely Occupational Therapy, Physiotherapy, Speech and Language Therapy, Dietetics and Podiatry. Health and Social Care (HSC) Trust staff from Occupational Therapy, Physiotherapy, Speech and Language Therapy, Dietetics and Podiatry have contributed to quantitative and qualitative data collection for this report. The role of these AHP services will be described in the next section. The group also recognises that, as with the rest of the population, care home residents may require intervention from any of the AHP professions depending on need. For example, the Creative Arts Therapies of Music Therapy, Art Therapy and Dramatherapy, described further in Appendix 2 are evidence-based clinical treatments which provide an innovative, creative and person-centred form of therapeutic support.

This paper outlines the role of AHPs with care home residents and the difference that AHP input makes to quality of life for residents in care homes. Within the section on the role of AHPs is a resident's account and two resident family accounts of their experience of an AHP service and the impact on themselves or their family member. Throughout the paper, there are a number of quotes from care home staff on their experiences of AHP services and the impact for residents. Throughout this paper the term "care home residents" is referring to those for whom care homes is their long-term residence, rather than those in intermediate or rehabilitation beds.

The models are categorised into two main groups-models of AHP input from core AHP services and models of AHP input from resource dedicated to care homes. Some temporary funding was secured through the No More Siloes Initiative (NMS), which enabled some dedicated AHP support to specific care homes. These two main models of AHP input have been evaluated to identify findings and themes.

The paper also describes the information gathered in order to evaluate the models. It includes quantitative data collection from Trusts; qualitative data from Trusts in form of case studies, examples of whole home approaches and regional engagement with AHPs working across

core and dedicated care home support teams. There was focused engagement with four care homes and AHP and Nursing staff across core AHP services and an Enhanced Care Response Team (ECRT) to seek views on and compare the two models. Context is provided on ECRT and further information on ECRT provided in Appendix 7. This engagement with four care homes and AHP and Nursing staff across core AHP services and ECRT focused on hearing experiences from staff. It is recognised that this is a small sample, with the main challenge in terms of engagement being staffing levels within care homes, particularly during Covid outbreaks. However, it was rich in qualitative information from these four care homes and allowed comparison across the two models.

Isolating data specifically for care home residents to the core AHP service was a challenge as it is not captured in this way, but rather is subsumed within all core AHP services activity data. Great effort was made to capture relevant quantitative data on care home AHP referrals retrospectively over a year but it is acknowledged that due to information systems challenges and the need for some manual searching that it is likely to be a best estimate. The year 2019/20 was chosen to focus on as this was pre-Covid and considered more representative of usual levels of AHP activity. The data captured from Trusts provided an estimate of the number of referrals into core AHP services for care home residents. The data could not be provided by all Trusts for all professions and so the actual figure is assumed to be higher.

To help provide a regional overview of AHP waiting times, data was taken from the DoH HSC AHP Services Information Briefing Dashboard. The source of the information on this dashboard is AHP Waiting Time returns from HSC Trusts to HSCB (now SPPG). The regional Integrated Elective Access Protocol (IEAP) defines the roles and responsibilities of allied health professions (AHP) referrals and waiting list management. The Ministerial AHP Access Target states that no patient waits longer than 13 weeks from referral to AHP service to commencement of treatment, using agreed Data Definitions Guidance (PHA, 2016). Data is collected on elective referrals to AHP services received for community and out-patients that require a booked appointment and which are not already open/active. Data is also collected on the number of patients waiting to be seen (at month end) by AHP profession and are subject to the Ministerial target that no patient should wait longer than thirteen weeks from referral to commencement of AHP treatment. These figures include those for care home residents although it was not possible to isolate out the specific data on care home residents. Rather this gives a high-level regional picture of elective referrals into core AHP services and waiting times.

Findings and learning are outlined and recommendations made in the paper based on all of this qualitative and quantitative information gathering.

3. Role of AHPs in Care Homes

3.1 Review of Literature as Evidence Base

The Enhancing Clinical Care Framework (ECCF) project highlights that there has been an increase in the proportion of care home residents with complex clinical healthcare needs and that "individuals in our care homes should receive the highest standards of care that holistically addresses these complexities." (DoH, 2021). It also raises the need to examine how to strengthen multidisciplinary support and specialist skills in collaboration with care home staff in order to support residents (DoH, 2021)

The NHS England paper "*Quick Guide: allied health professionals enhancing health for people in care homes"* (produced in collaboration with AHPs and the Enhancing Health in Care Homes Team NHS England, 2019) available here demonstrates how AHP services can support the framework for enhanced health in care homes (NHS England, 2016).

It highlights that AHP services can support the enhanced health in care homes framework (NHS England, 2016) in terms of nutrition and hydration; rehabilitation and reablement; end of life and dementia care; workforce and digital and technology (NHS England, 2019). Key themes were identified as requiring improvement, including ease and equity of access to AHP services; whole home approaches to training and education; supporting care homes with structured approaches from AHPs to reduce the need for professional intervention (NHS England, 2019). The NHS England Quick AHP guide for care homes paper then provides a number of case studies. This paper will include the approach of providing local case studies to demonstrate the role and impact of AHPs in care homes in Northern Ireland.

The British Geriatrics Society (BGS) paper "Ambitions for change: Improving healthcare in care homes" describes a number of health concerns for care home residents, which include falls, nutrition and hydration (BGS, 2021). The BGS, which includes membership from geriatricians, GPs, nurses and AHPs, considers healthcare for older residents in care homes as a priority. (BGS, 2021). The paper describes what good should look like and makes 11 recommendations which include funding for enhanced healthcare services in all care homes, with a definition of the required standard multidisciplinary team; funding for the development of care home staff and equitable access to rehabilitation and other services as needed. (BGS, 2021)

3.2 Overview of role of AHP services for care home residents

In the next sections the role of each of the five individual AHP professions will be outlined. It is recognised by the task and finish group that AHPs do not work in isolation but rather as members of multidisciplinary teams, with AHPs often working closely with each other and with other professions in order to improve resident outcomes. This includes individual clinical interventions and whole home approaches to improve quality of life, health and

wellbeing, independence and safety and to reduce impairment and inappropriate hospital admissions.

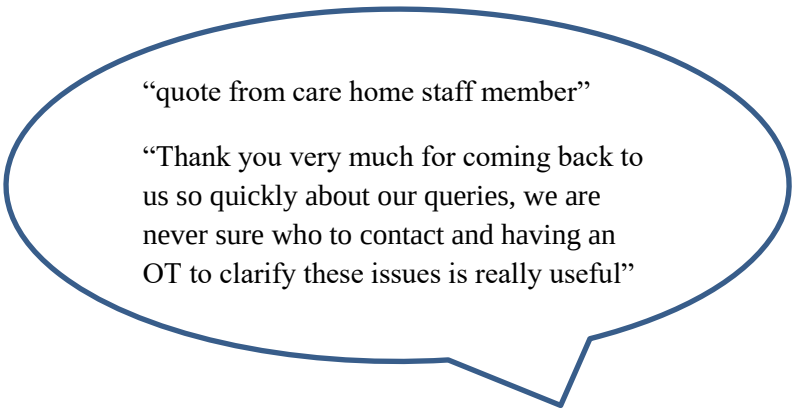
Data collected from Trusts showed that the main reasons for referrals to core AHP services from care homes, in alphabetical order, are:

- Dysphagia-eating, drinking and swallowing difficulties
- Falls
- Mobility
- Nutrition
- Seating and positioning
- Social isolation

Research has found that the rate of prevalence and incidence of dysphagia is between 50-75% of nursing home residents (NHS England, 2017). It is also found that the rate of falls in care homes is almost three times that of older people living in the community and that injury rates are higher, with "30% of people admitted to an acute hospital with a hip fracture coming directly from a care home". (DoH, England, 2009).

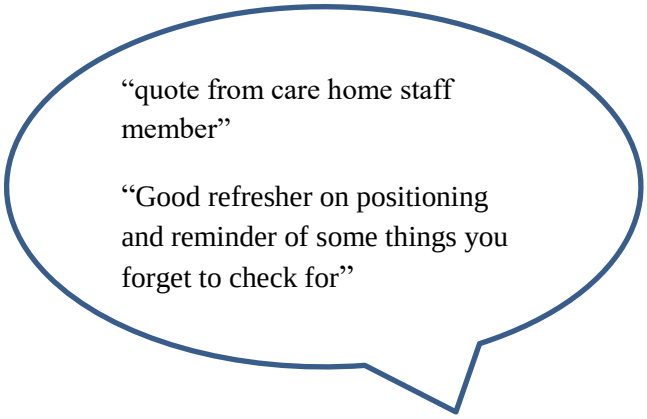
3.3 Key role of Occupational Therapy with care home residents

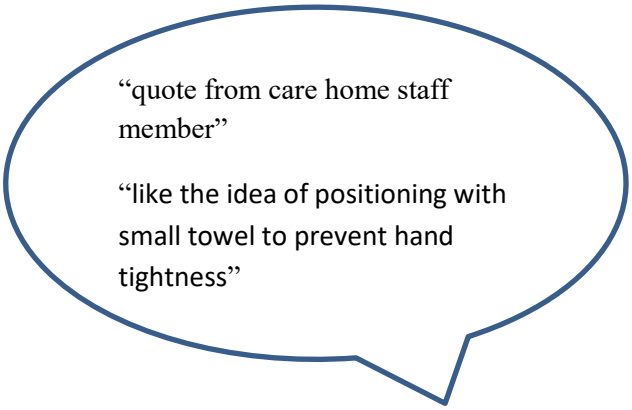
- Assessment for seating, wheelchair and postural management
- Advice on meaningful activity and individual personalised plans/routines for residents. Liaising with activity coordinators to help advise on better social engagement.
- Advice regarding manual handling especially where this affected the residents' ability to sit up out of bed or to come out of their room for activities.
- Falls prevention strategies and assessment and advice for those who have had recent recurrent falls
- Assessment and prescription for pressure relief where required for wheelchair or specialist seating system



3.4 Key role of Physiotherapy with care home residents

- Educational messages and training to care home staff and strategies to increase physical activity, prevent deconditioning, improve strength and balance and mobility, manage long-term conditions and maintain physical and respiratory functional status
- Manual Handling
- Falls Prevention
- Encourage social interaction, improve psychological well-being.
- Strategies to improve for positioning and weight bearing
- Early intervention to prevent increase tonal changes and contractures

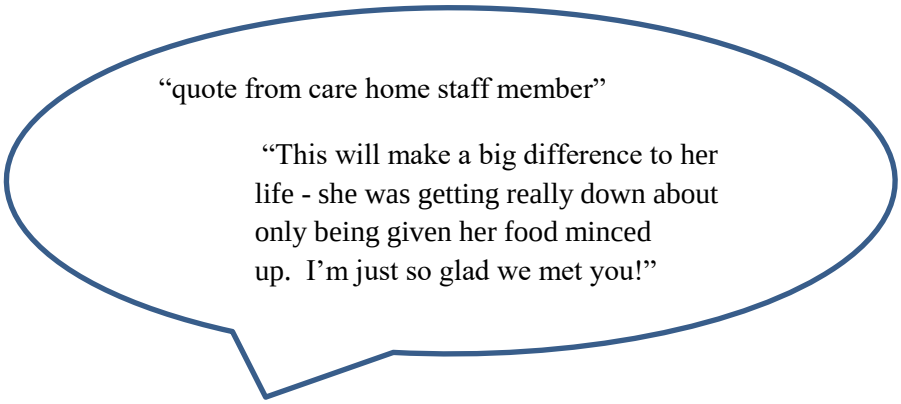


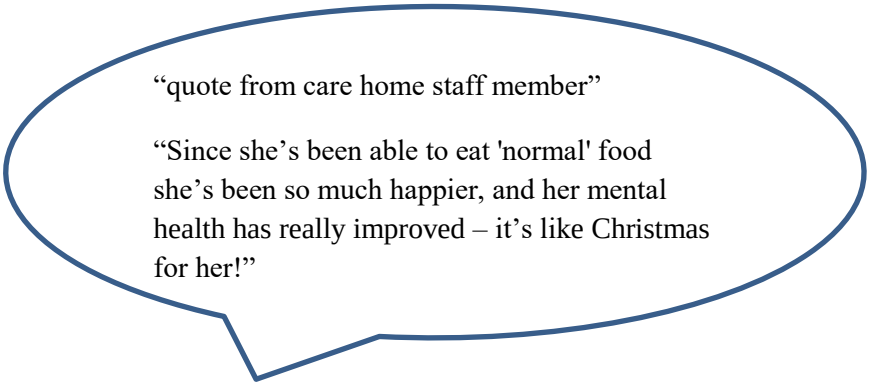


3.5 Key role of Speech and Language Therapy with care home residents

- Eating Drinking and Swallowing support-providing swallowing assessment, advice and intervention to support and promote safe and optimal nutrition and hydration for residents with swallowing difficulties. Emphasis on risk management within context of quality of life, patient choice and least restrictive approaches to management of swallowing difficulties.
- Education and training for care home staff to maintain and assure quality around dysphagia
- Assessment of communication.

- Advice and strategies to improve communication.
- Therapy intervention and programmes for speech and language where appropriate.
- Support alternative and augmentative forms of communication where necessary.

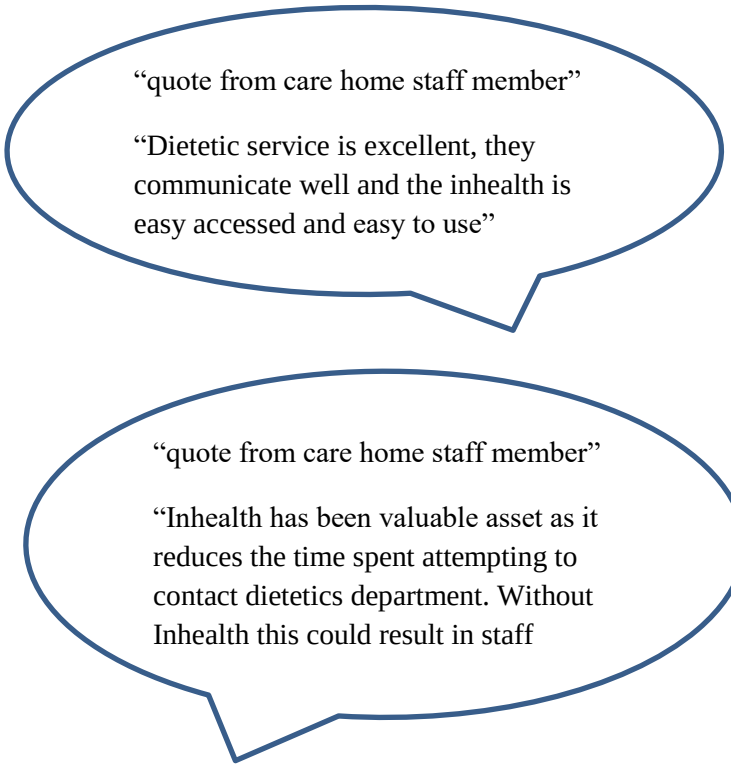




3.6 Key role of Dietetics with care home residents

- Management of nutrition.
- Work in partnership with nursing home staff, including catering staff, to ensure nutritional care plans are in place.
- Holistic nutritional assessment, treatment and education of residents when required.
- Nutritional support (oral and enteral), eg for residents with dysphagia, diabetes and weight reduction
- Ongoing provision of MUST and nutritional education to care home staff.
- Ensuring the appropriate use of nutritional supplements with the home.
- Education to residents and relatives, eg on Diabetes

- IN Health, an online management system, has been rolled out to a number of care homes which involves monitoring patients who have been referred to dietetics for nutritional support and improves patient care



3.7 Key role of Podiatry with care home residents

- Foot protection care for those at greatest risk of foot ulceration and limb loss.
- Education and advice for care home staff and residents on foot care, foot health, skincare and risks to foot health as required.

3.8 Accounts of Resident and/or Relative Experience

The task and finish group had the interests of residents at its core throughout the evaluation and in making recommendations. There was a strong recognition of the importance of this work being resident centred and the need to hear the voices of residents and/or families in relation to their experience of AHP services.

Invitations to hear resident and/or relative experience of AHP services were made in a number of ways by the task and finish group, including sharing the request with Trust AHP and Nursing colleagues, care homes during the engagement with four care homes and through the Chair of the ECCF Workforce subgroup.

It was agreed that the Patient Client Experience regional office in the Public Health Agency would take the lead on collecting this feedback. Names of residents and families and care homes were not shared with the wider task and finish group with nominations being sent directly, as requested, to Patient Client Experience. It was agreed that these would be shared anonymously within this work.

The task and finish group wish to extend their thanks to the resident and relatives for giving their time to share their experiences. Thanks is also extended to Public Health Agency Patient Client Experience colleagues for their time in gathering this vital feedback and in facilitating these accounts in the way which best suited the relative or resident.

Three people agreed to share their experience. Including firstly, a relative of a care home resident and is in relation to their experience of speech and language therapy for their Mother; secondly, a resident and relates to their experience of physiotherapy; and thirdly, a relative of a care home and is in relation to their experience of occupational therapy for their Wife. These experiences are viewed with the lens of "What matters to you" and the following themes have been identified in the narrative. Each theme is illustrated using quotes directly from the story to ensure the voices of the stories are heard.

Quality of life

The resident &relatives reflected on ways that the support received from the AHP in-reach care contributed to the resident's quality of life. Being able to enjoy food again after assessment by Speech and Language Therapy positively impacted upon the resident's mood and their experience of living in a care home.

"…It made a big difference to Mum having proper diets. She would have complained about the food but after going back to a normal diet would say the food is lovely, she enjoys getting roast pork and potatoes… It was a chance meeting on that day, she had been struggling for weeks and weeks in the home, and is now getting normal proper food… It was so helpful that the SLT was there on that day, has cheered her (resident) up and us (family) as well…" (Speech and Language Therapy)

The support from Physiotherapy helped the resident develop leg strength and to be able to walk.

"…They (Physiotherapist) gave me exercises and helped with my leg. I do my exercises every morning and can walk each day a bit on my own. They are good..." (Physiotherapy)

The equipment provided by Occupational Therapy enabled the resident to go into the outdoor area of the care home.

"…The OT got the seat for to help get my wife out of bed. It is safe and good for her, she has half an hour a day of fresh air every day, this was good after having so long of being in bed… She (resident) really does like her half hours out, would see the smile on her face…" (Occupational Therapy)

Staff

Relatives reflected on the caring and respectful manner of the AHP in-reach staff when providing treatment and the approach by staff was highly valued.

"…She (SLT) related well with her (resident), she let Mum eat away and watched her without being intrusive, and was brief when checking her mouth. Mum has dementia and the SLT had a careful manner and didn't upset her, at the time Mum could understand why the girl was doing what she was doing and was able to say 'now I can get a good meal'…" (Speech and Language Therapy)

"…They were first class the whole way they went about it. They were very considerate of her condition. I was impressed. Manner matters a lot and they showed a caring manner for the patient in the way they did their work. Some people don't show this care and respect with people with dementia, but I was well pleased and I am very protective of my wife…" (Occupational Therapy)

Reassurance for the family

The relative reflected on the family being reassured following the SLT in-reach care, this was due to contentment from the impact of revised diet advice on the resident; and from having a point of contact if they had any concerns.

"…It turned the experience of being in a care home around and made a big difference to her and to the family… Is good now that we have met the SLT, and she assured us if things went downhill that we could talk to her and we (family) now know how to contact her…" (Speech and Language Therapy)

The family being in attendance during the appointment and present to see the care provided was reassuring to the relative.

"…The OT who came out was very good, very professional. The man who brought the seat was very good too… The way they were with my wife, their manner was good. It was professional the way they went about it, gave me confidence in her (OT) and how they went about setting up in the chair…" (Occupational Therapy)

Care & treatment
The resident reflected on the care received from the Physiotherapy in-reach as a positive experience, and referred to being helped to walk by having access to equipment and from the doing the prescribed exercises daily using the leg band given.

- Equipment

"…The physio gave me a thing to put round my leg to walk…. Then got the rollator and walked. With a rollator I could walk fine and the Physio got me that…" (Physiotherapy)

- Treatment

"…They used to see me every week. Have got my exercises to do and I am happy enough…" (Physiotherapy)

Timing of review
The relative reflected on the importance of the timeliness of the AHP review and stated having this as part of the admission into the care home would have been beneficial to the resident.

"…When we met the SLT this was purely coincidental and she overheard us. It would help if when XXXXX (resident's name) went into the home at the beginning if she had had a review by an SLT or that it was part of her admission. If that chance meeting had not happened then her unhappiness would have gone on for longer…"

4. Models of AHP input to care homes in Northern Ireland

4.1 Overview of models

The most common model across the region is of referrals for care home residents into core AHP services.

There are some examples where core AHP services have allocated staff to work specifically with care home referrals.

There are a number of examples where there is, or was for a period of time, some AHP input dedicated to care homes. Models vary and some were pilots, targeted at specific homes in specific Trust areas, depending on resource capacity and funding. Data was sought from these examples to help compare when AHP input is from core services with when AHP input is from resource dedicated to care homes. This data is limited by the small number of examples across the region where there is dedicated AHP input to care homes.

4.2 Regional engagement session with AHPs to describe models

In order to further understand the two models, there was a regional engagement event with participation from thirteen AHPs from across core teams and care home support teams. This was conversational in nature and AHPs were asked to describe the process when care home residents are referred into core AHP services and when they are referred into a dedicated care home response team.

This is a summary of the process described for the two models and the views of the group.

Process when referral is into core services	Process when referral is into a dedicated AHP care home support team
Referrals are made into core AHP services in different ways, including online to central booking, by Call Management and by post For some teams, referrals currently come via GP rather than directly from care homes Referrals are for individual residents There is very limited capacity for any training or education other than in relation to individual residents There was one report of referrals waiting up to 12 months	Referrals are made into AHP services in care home support teams in different ways in different areas, including by email and post Referrals can be directly to the care home support team or via core AHP services redirecting the referral In some dedicated AHP teams there is clinical input and in some the dedicated team refer onto core for routine referrals In some dedicated AHP care home response teams referral is triaged using a holistic approach, agreeing which profession needs to see the resident first Training needs are identified with care home staff and training is routinely built in with time dedicated to this
Summary of views from this regional AHP engagement	
There is a lack of regional consistency in care home referral processes into AHP services. Any examples of dedicated AHP input to care home support teams are relatively new and further investigation would be useful to determine the best model of dedicated input, eg whether it would include clinical input or linking closely with core services Joint working across the multidisciplinary team and with care home staff was considered best for resident outcomes, taking a holistic approach to care and treatment	

It was agreed that referrals into a dedicated AHP care home support team were more timely and coordinated It was the group's view that AHP input within a dedicated Care Home Support Team was more responsive and flexible, with plans being able to adapt more quickly when needed

4.3 Examples of Case Studies

In order to highlight the impact of AHP services to care home residents this section provides a summary of local case studies. These case studies are from areas which currently have or have had dedicated AHP input on a temporary basis. The case studies are outlined in more detail at Appendix 3

Case Study Example	**Profession/s**	**Key improvement elements**
Dietetics supporting care homes in review of menus in accordance with nutritional guidelines	Dietetics	• Whole home approach • Supporting with structured AHP public health approach
Food First as first line approach rather than oral nutritional supplements	Dietetics	• Whole home approach • Supporting with structured AHP public health approach
Functional assessment / manual handling needs	OT	• Advice to care home staff on ➢ use of hoist slings, ➢ resident's level of ability ➢ strategies to promote activity and social engagement
Improving functional mobility to reduce risk of falls	OT	• Advice to care home staff on ➢ management of environment to reduce falls ➢ management of resident's mobility ➢ communication challenges and advice to work with SLT
Swallow assessment and MDT plan to reduce risk whilst continuing to enjoy food.	SLT	• Risk management advice • Resident supported to continue enjoying food
Improving manual handling and mobility and reducing falls risk in partnership with physiotherapy and wider AHP team	Physio	• Physiotherapy and wider AHP teamworking to improve resident outcomes • Provision and replacement of equipment

		• Falls prevention strength and balance programmes • Mobility training • Postural management
Diabetes foot pathway and application for care homes	Podiatry	• Regional care pathway • Prompt access to appropriate care, particularly those at risk with active foot ulceration
Multidisciplinary team working with resident demonstrating functional decline	Multidisciplinary Team	• Management of swallow • Nutrition • Management of mobility • Functional ability

4.4 Examples of impact from whole home AHP approach

As a whole home approach is the main approach of any dedicated AHP care home teams, examples of impact using this approach were also gathered from Trusts. A whole home approach recognises the importance of partnership working between AHPs and care home staff for the benefit of all residents. Using a whole home approach to training, education and advice which supports and empowers care home staff with structured AHP approaches should reduce the need for individual referrals and ensures that every care home resident is supported to live the best life possible. This approach supports the delivery of high quality, safe and effective care for older people in care homes, maximising quality of life and health outcomes and enabling identification of risk and need for early intervention.

There are a number of examples included as "score cards" in Appendix 4 for more detail. One brief example of this whole home approach from dietetics is outlined here.

Nutritional Home Whole Approach
Purpose
➢ Using the "Prevent, Anticipate, Avoid and Treat" Model – Dietitians and Dietetic Assistants working in partnership with Care Homes to ensure nutritional care plans are in place.
Actions
➢ 24 care home menus audited against PHA nutritional guidelines and menu checklist. ➢ 15 snack trolleys audited ➢ 2 care home food fortification levels assessed

Impact
➢ Compliance with PHA menu checklist before dietetic input-88% ➢ Compliance after dietetic input (2 homes)-100% ➢ Compliance with expected snack provision before dietetic input-66% ➢ Compliance with expected snack provision after dietetic input (2 homes)-100%

Another example of the whole home approach is from Speech and Language Therapy service to Care Homes and is outlined below

Co-production of a whole home approach to eating and drinking safety
Purpose
➢ Swallowing difficulties increase risks of choking, pneumonia and malnutrition with approximately 67% of care residents having the condition. Regional work has identified key actions needed to keep residents with swallowing needs safe and the PHA has issued key messaging to support this ➢ However, recommendations are not always followed which impacts on resident safety. Wanted to know the barriers to safe mealtimes and how to increase the compliance rate with clinician recommendations
Actions
➢ Identified pilot home to work with to increase compliance ➢ Audited compliance with recommendations looking at texture and fortification of kitchen prepared meals only. ➢ Audit showed highly variable and irregular data and in terms of fortification. Meal safety issues were noted. Eating and drinking safety is reliant on the strength of the chain across professionals, so needed to look at meal safety in its entirety. Needed a whole home solution. ➢ Broke the audit down further into key areas, developing a tool to identify and feedback to the home regarding their mealtime strengths and weaknesses. ➢ Compliance wasn't only measure for safety as some errors are more serious than others. We devised a pass/fail system (for clinician use only) to identify high risk safety breaches, important from a governance perspective. With the aim of capturing risks before incidents occur.
Impact
➢ By training staff to use the audit tool, engaged them with the regional safety messages; embedding the education into practical action for the home. ➢ Training was not only for care staff but targeted for management and catering too, with food fortification to combat malnutrition and meal feedback charts for resident choice.

- Initial figures are very promising with a median baseline pass rate of 10% pre-training to 80% post training and a consistent overall compliance score of over 60%. A real boost to patient safety!
- Plan to scale up to include further homes

A third example of the whole home approach is from Podiatry regionally.

Foot health education for care home staff
Purpose
➢ To promote foot health in care homes by developing regionally agreed information for carers and staff ➢ Public health advice on foot care and preventative advice.
Actions
➢ Public Health agency and Regional Podiatry HSC departments produced information for care homes in NI on personal foot care, awareness of who should be refer to podiatry and public health advice on foot care and preventative advice. ➢ Two videos produced and poster of information regarding personal foot care and how and when podiatry intervention is required. These were published by PHA on their website and poster sent to each care home. ➢ Video 1 focused on Healthy Feet for care Home residents – including how to check feet and cut toe nails ➢ Video 2 focused on Hints and tips for healthy feet. Including footwear advice and what are important foot checks to carry out. ➢ The poster combined the information from the 2 videos
Impact
➢ Referral pathways were identified for care homes regionally in NI with understanding of podiatry care provided by HSC service and how to refer to service when required ➢ Footwear advice was provided which will impact on falls prevention ➢ Personal foot care advice was provided as required

5. Findings from Trust AHP Activity Data

5.1 Methodology

Activity data was sought from HSC Trust AHP services and HSC Trust Information colleagues using a template developed by the Task and Finish Group.

Data was sought for referrals for care home residents to core AHP services retrospectively over a year. It was agreed by the task and finish that it would be most reflective of normal position to gather data on activity in 2019/20, i.e. pre Covid. It was also agreed that data would focus on long term residents for whom the care home is their home, rather than information on intermediate care activity as AHP models of input would be different for that group.

Data was also sought from Trusts for referrals for care home residents to dedicated AHP care home support teams, where there are any. As any examples of dedicated input tend to be more recent, activity data was sought over an 8-month period in 2021.

Information systems challenges soon became apparent when activity data specifically on care home residents was sought from Trusts. In light of this, data was also taken from the DoH HSC AHP Services Information Briefing Dashboard, with the source of the AHP information on this dashboard being AHP Waiting Time returns from HSC Trusts to HSCB. Data is collected on elective referrals to AHP services received for community and out-patients that require a booked appointment and which are not already open/active. Data is also collected on the number of patients waiting to be seen (at month end) by AHP profession and are subject to the Ministerial target that no patient should wait longer than thirteen weeks from referral to commencement of AHP treatment. These figures include those for care home residents although it was not possible to isolate out the specific data on care home residents. This gives a high-level regional picture of waiting times for elective referrals into core AHP services. Waiting time data was taken from the month ending March 2020 as this was the year data was collected from Trusts on number of AHP referrals for care home residents. Waiting List information is based on active waits as at the month end position and is a snapshot figure.

5.2 Summary of Quantitative Data Findings

As previously stated, great effort was made to capture relevant specific data on care home referrals to core AHP services but it is acknowledged that due to information systems challenges, eg the fact that many systems could not easily isolate data on referrals for care home residents and the need for some manual searching that there are some gaps and is a best estimate rather than entirely accurate and reliable.

A whole home approach is the main focus of dedicated AHP input within care home support teams and so individual referrals are low, with some signposting to core services if referrals

are required. It was not possible to get data from most Trusts in relation to dedicated teams as AHP input to Care Home Support Teams tend to be quite limited in nature.

The quantitative data findings from Trusts are outlined in more detail at Appendix 5, for individual referrals into core AHP services, and Appendix 6, for individual referrals into a dedicated AHP service in a Care Home Support Team

Trust information available for this evaluation included:

- Number of AHP referrals received for Care Home residents over one year for HSC Trust core AHP services. This is shown in Figure 1 of Appendix 5 showing the total number of referrals across all the professions from care homes being 14, 290. However, this is based on Trust returns which had gaps due to IT limitations and so there will be an underrepresentation of referrals. Therefore, it is assumed that the actual figure is higher.

- Waiting time information on core elective AHP referrals. Again, it must be highlighted that this information is from all core elective AHP referrals and not specifically related to care homes. It does however show that waits in the professions can be in excess of 13 weeks. Further detail can be seen in Figure 2, Figure 3, and Figure 4 of Appendix 5. In summary:
    - The total waiting at 31st March 2020 for first AHP appointment for these five professions across the region is 62,884.
    - The total waiting more than 13 weeks at 31st March 2020 for first AHP appointment for these five professions across the region is 18,584.
    - The percentage breaching waiting time target of 13 weeks by profession across the region as at month ending 31 March 2020 ranges from 18% of referrals for podiatry to 43% of referrals for Speech and Language Therapy.

- Number of AHP referrals received for Care Home residents over 8 months for dedicated AHP support in Belfast Trust (BHSCT) Care Home Support Team. A model of dedicated AHP input was only available in limited areas and so the data is not representative of entire professions or trusts. Rather it is to give a high-level picture of referral activity and responsiveness when this model is available and when individual referrals are required. An example of how responsive AHP services can be when included within a Care Home Support Team was shown by BHSCT Care Home Support Team. Data provided from this team for 8 months in 2021 in relation to Speech and Language Therapy (SLT) and Occupational Therapy (OT) activity is shown in Figures 5 and 6 in Appendix 6. Referral numbers are low and this fits with the description of AHP care home support teams offering a whole home approach. There were 49 referrals across SLT and OT in this dedicated team over 8months with average wait times between one day and three weeks.

- Main reasons for referral were also captured from Trusts and these are outlined in section 3.2 of paper

6.Findings from engagement with four care homes and AHP and Nursing staff across core AHP services and Enhanced Care Response Team (ECRT) to seek views on and compare the two models

In order to gather views from staff on the different models of AHP input, there was engagement with four care homes and AHP and Nursing staff across core AHP services and ECRT to seek views on and compare the two models.

It was agreed that the engagement would focus on one Trust area, Northern Health and Social Care Trust (NHSCT), which had piloted AHP input as part of their multidisciplinary Enhanced Care Response Team (ECRT) for care homes over a 15-month period until March 2022. It was acknowledged that the pilot had facilitated more substantial dedicated AHP input to specific care homes than in other Trust areas. This allowed these care homes to have very direct experience of AHP input with resource dedicated to care homes.

It is recognised that four homes is a small sample, with the main challenge in terms of engagement being staffing levels within care homes, particularly during Covid outbreaks. However, it was rich in qualitative information from these four care homes and allowed comparison across the two models.

6.1 Context of Enhanced Care Response Team (ECRT)

Evaluation reports have been developed separately by Northern Health and Social Care Trust (NHSCT) on ECRT and this information was shared with the task and finish group.

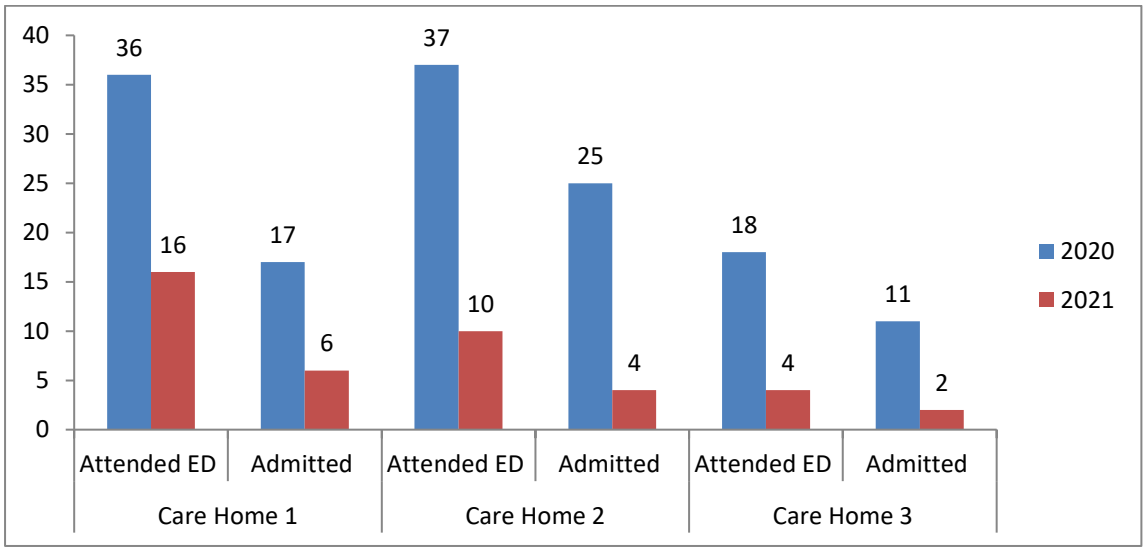
The multidisciplinary Enhanced Care Response Team (ECRT) was funded through No More Silos (NMS) funding as part of the Department of Health (DOH) Rebuilding programme (REACH, 2022). The full make up of the team, which includes AHPs is in Appendix 7.

"The service commenced in 3 East Antrim (EA) care homes in mid-January 2021 with the team spreading to a further 6 care homes between April and May 2021 with a total resident population of 548 residents. NMS funding enabled a scale up of the pilot into the Mid-Ulster Locality, commencing in 2 care homes in November 2021 spreading to a further 4 care homes by April 2022 with a Mid Ulster total resident population of 359 residents" (REACH, 2022)

The aim of the ECRT pilot was "*To reduce avoidable ED attendances by 10% from care homes over the pilot period from the same period in the previous year through delivery of a MDT Enhanced Care Response Team."* (REACH, 2022)

One aspect of the NHSCT evaluation was to collate rates of residents' attendance to ED and subsequent admission or discharge/transfer for the 3 pilot homes in 2021 and compare with the same period in 2020. Each home showed a reduction in the number of resident ED attendances in the 2021 pilot period. (REACH report, 2021). This is shown in table below from the REACH report (2021)

Number of Nursing & Residential Home Patients Presenting at ED (01/01/2020 - 19/03/2020 & 01/01/2021-17/03/2021) (REACH report, 2021)



Further data as examples of ECRT outcomes is included in Appendix 7 with the ECRT evaluation concluding "there is strong association between the input from the ECRT into care homes and their reduced resident ED attendance, thereby creating a huge potential to release capacity within the Emergency Department ..." (REACH, 2022)

6.2 Methodology

To compare care homes views of the two different models, input from core AHP services and input from dedicated AHP service within the Enhanced Care Response Team, care homes were approached by NHSCT colleagues working in the Care Homes REACH Team and invited to take part in engagement to seek views on the two models.

Four care homes agreed to take part, two homes which received AHP input from ECRT and two homes which received AHP input from core AHP services. This allowed comparison across the two models. As the 15-month period of the pilot of dedicated AHP input ended in March 2022, homes were asked to base their views and responses on the discussion areas below on experience of service until March 22.

The engagement took the format of listening events. Homes were given the option of face to face or virtual meetings, and all chose virtual meetings. The sessions were conversational

listening events with some questions to help with the conversation discussion format. As stated, participants were asked to base their views on experience of services until March 22.

In addition to engagement with care home staff, there was also an engagement event, using the same conversational format, with AHPs and Nursing colleagues across the same Trust area in NHSCT who had working experience of both AHP input from dedicated AHP services within ECRT and input from core AHP services. Views on both models were discussed within the event.

The discussion areas in the events were:

- The referral process and ease of same
- Waiting time from individual referral to assessment when required
- Views on partnership approach between AHPs and care home staff
- Impact of AHP services for residents
- Training or advice provided from AHP staff
- Satisfaction with service and suggestions for improvement

These discussion areas were used to describe the views gathered from the engagement events and the findings. The findings from the engagement events are described in more detail in Appendix 8, including the findings from engagement with the two homes which referred into ECRT; findings from engagement with the two homes which referred into core AHP services and findings from engagement with AHP and Nursing staff in ECRT and AHPs in core AHP services. In section 6.2 below there is a summary of all of these engagement findings.

6.3 Summary of engagement findings to seek views on and compare the two models

- There was greater satisfaction in all areas discussed in all of the engagement sessions with the four care homes and nursing and AHP staff when the AHP model of input was from the AHP service within ECRT with dedicated resource for care homes
- The referral process is easier and more streamlined when into the ECRT AHP service with resource dedicated for care homes. It is also of note that having a dedicated AHP service allows the use of a whole home approach where all residents benefit.
- Waiting time from individual referral to assessment when required is reduced when the referral is into the ECRT AHP service dedicated for care homes
- The partnership approach between AHPs and care home staff is much stronger when the model of AHP input is from the ECRT dedicated AHP service for care homes.
- The impact of AHP services for residents was reported as high with both models of AHP input. Although it was reported that the more timely intervention from the ECRT AHP service dedicated to care homes had a more positive impact on quality of life and health outcomes.
- Training and advice was provided by AHP staff when the model of AHP input is from the ECRT AHP service dedicated for care homes. There wasn't capacity for this, other than

advice regarding individual referrals or general written guidance such as leaflets, when the model of AHP input is from core services

- Satisfaction with service was highest when the model of AHP input is from the ECRT AHP service with resource dedicated for care homes.

7. Learning identified from overall findings

- The model is reactive when referrals are made into core AHP services. Issues are dealt with as they appear, without the capacity to carry out a root cause analysis or provide training to staff within homes.

- When the AHP input model is from core AHP services, individual referrals are triaged as urgent or routine and then added to the appropriate waiting list. Urgent referrals are prioritised and responded to urgently, eg 48 hours acute exacerbation of respiratory condition. Routine referrals should be seen within the ministerial and IEAP AHP access target of 13 weeks. The data would suggest that this is not always the case as some elective referrals are waiting significantly longer than this. This data includes all referrals across all age groups and programmes of care. Figure 3, in Appendix 5, illustrates breakdown of those waiting more than 13 weeks for first AHP appointment by profession at month ending 31 March 2020 and Figure 4, in Appendix 5, illustrates percentage breaching waiting time target of 13 weeks by profession across the region as at month ending 31 March 2020 (Source: AHP Waiting Time returns from HSC Trusts to HSCB).

- Case studies support that individual outcomes are improved when AHPs are members of the Care Home Support Team

- Examples of the impact of whole home approaches provided highlight that a population health approach is appropriate with this client group, with the opportunities afforded from residents and their families, care home staff and AHPs working in partnership.

- A whole home approach is the main approach used in an AHP model of input with resource dedicated to care home support teams. Using a whole home approach to training, education and advice which supports and empowers care home staff with structured AHP therapeutic care planned approaches aims to reduce the need for individual referrals and ensure that every care home resident is supported to live the best life possible. A whole home approach recognises the importance of partnership working between, residents, loved ones, AHPs and care home staff to enhance the quality of life for all residents.
    - This approach supports the delivery of high quality, safe and effective care for residents in care homes, maximising their quality of life and their health

outcomes, to include the fundamental care areas of nutrition, eating, drinking and swallowing, mobility, postural management, communication, social wellbeing and independence.

- It can also enable the early identification of resident risk and prompt early AHP clinical intervention when required to reduce further clinical decline and help maintain the resident safely in their care home setting with potential for reducing the number of resident inappropriate admissions to hospital. Evidence suggests that some care home residents have multiple admissions and discharges through acute hospitals which impacts quality of life as well as adding pressure to patient flow (BGS, 2015; BGS, 2021; DoH,2020)
- It allows a holistic and integrated approach to resident need with the multidisciplinary team working together to collectively prioritise the timely response from the most appropriate professional so to maximise resident health outcomes, agreeing who needs to see the resident and when in order to improve outcomes. It allows for collaborative approach to informed advanced care planning.

- AHP projects noted in this report have offered a blueprint to further shape the AHP enhanced service into care homes model and this should be further explored.

- When there was capacity in teams with dedicated AHP resource for clinical input if required for early intervention to reduce clinical decline waiting times were significantly reduced, eg that shown in Figures 5 and 6 in Appendix 6. This was through early identification of resident risk prompting early AHP clinical intervention. In some care home support teams individual referrals continue to go to core AHP services when required. Whether AHP clinical intervention is provided by a dedicated AHP service for care home residents or by core AHP services will be influenced by need and resource.

- It's recognised that examples of AHP input dedicated for care homes are not widespread and there would be a resource issue to make this service available across all care homes. Depending on level of resource, a dedicated AHP team could include an early detection and response AHP service in addition to a whole home approach

- Evidence of cost efficiencies were shown in the NHSCT evaluation of the multidisciplinary Enhanced Care Response Team, which included AHP input. The ECRT evaluation showed that ED attendances were reduced when there is a dedicated multidisciplinary team (REACH, 2021; REACH, 2022).

- It is considered it would be of value to include mapping interfaces with other trust services.

- Care Home staff reported in engagement that they valued the strong partnership approach when they had AHP input with resource dedicated to their care homes. In particular they said they valued being able to easily seek advice.

- Care Home staff also reported in engagement that they valued tailored education and training and thought it would be better if this was more frequent in order to facilitate all staff receiving this.

- It was found in engagement that there is reported benefit to residents and staff when AHPs work as part of a dedicated AHP team for care homes due to the close teamworking and co-delivery model. This allows greater understanding of each other's role and how to best work together for improved resident outcomes.

8. Recommendations

These recommendations have been made by the Task and Finish group using all of the quantitative and qualitative information available.

The paper highlights that quantitative activity data collection from Trusts was challenging in terms of understanding the current requirement for AHP input to care homes as Trusts do not capture data specifically for care home referrals and so there is a risk that the quantitative activity data collected is not entirely accurate for this client group. This need for improved data collection is accepted as a next step in the recommendations to ensure best value for money in meeting the needs of the care home resident population.

In light of the challenges with isolating out Trust AHP data for care homes, all the elements of the evaluation have been considered when making recommendations including engagement with key stakeholders, collecting case studies and examples of whole home approaches and taking evidence from the evaluation of the NHSCT multidisciplinary Enhancing Care Home Response Team (ECRT) evaluation which AHPs were part of and which NHSCT colleagues on this task and finish group also led on.

Recommendations are:

- The evidence shared from case studies, whole home approaches examples and the NHSCT ECRT evaluation (REACH,2021; REACH 2022) is pointing towards improved patient outcomes and whole system benefits when a dedicated AHP service is in place. It is recommended that there is a dedicated AHP service for care home residents in each Trust area, providing a whole home approach, with AHP input from across the five AHP professions of Occupational Therapy, Physiotherapy, Speech and Language Therapy, Dietetics and Podiatry.

- Improved data collection which better details the requirement for and impacts of AHP input to care homes in order to ensure best value for money. This should include focus on population outcomes. Consideration should also be given to data mechanisms which enable capturing Trust activity data on this specific group, eg building in to Encompass.

Next Steps:

- More exploration to identify and quantify the resource that would be required to adequately support homes with a regional model of AHP input dedicated for care homes.

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11. Appendices

Appendix 1: Task and Finish Group Membership

Mary Emerson	Lead AHP Consultant, Public Health Agency (Chair)
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Rose McCullagh	GP
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Elaine McConnell	AHP Lead, BHSCT
Eileen Dolan	AHP Lead, WHSCT
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Sharon Murphy	Physiotherapy, SEHSCT
Jennifer Madden	Podiatry, BHSCT
Jennifer Young	AHP Lead, SEHSCT AHP Care Home Support Team
Linda Craig	Patient Client Experience Lead, PHA
Fionnula Mann	SLT, SEHSCT
Marie-Claire Kane	Dietetics, NHSCT
Keri Nicholl	SLT Lead for Adults, NHSCT
Julie Foster	Lead Nurse REACH (Responsive Support, Education and Anticipatory Care with Care Homes Team) NHSCT.
Shane Breen	Lead AHP Consultant-in seconded role to DoH for “Intermediate Care – A Regionalised Approach”
Michelle Laverty	Nurse Consultant-seconded to DoH for “Intermediate Care – A Regionalised Approach”
Maria Loughran	Lead Nurse, REACH team

Appendix 2: Role of Creative Arts Therapies in Care Home settings

The Creative Arts Therapies are Music Therapy, Art Therapy and Dramatherapy. These are evidence-based clinical treatments which provide an innovative, creative and person-centred form of therapeutic support.

Music therapy uses music-based interactions in a therapeutic relationship to support physical, mental, social, emotional and spiritual wellbeing. Music therapists use both pre-composed and also newly created music that is tailored to the individual's needs and can involve listening to music, composing or improvising through instrumental play and song-writing, singing, and movement. Music therapy is widely recognised as an important and effective means of therapeutic support for people with all forms of dementia. A report published in January 2018 summarising the work of the Commission on Dementia and Music states that music helps to minimise some of the symptoms of dementia, such as agitation, and can help to tackle anxiety and depression, and that we can also observe the considerable value of music in improving the quality of life for people with dementia, by helping to increase social interaction and decreasing stress hormones. Available at https://ilcuk.org.uk/wp-content/uploads/2018/10/Commission-on-Dementia-and-Music-report.pdf

Art therapy uses the visual arts as a form of psychotherapy to encourage clients to explore issues, communicate and express themselves, discovering a personal visual language as a bridge to communication when verbal approaches are insufficient.

In Dramatherapy the performance arts are utilised in a therapeutic relationship and process to effect psychological, emotional and social change. The dramatherapist engages with people through their own communication style, using dramatic context such as movement, sound, role play, story, and body language in a playful and indirect approach involving creativity, imagination, learning, insight and personal growth.

Clinical Outcomes:
The Creative Arts Therapies can improve wellbeing and quality of life for care home residents, specifically supporting long-term outcomes in the following areas:
Emotional/psychological
- reducing symptoms related to mental distress, agitation, anxiety and depression;
- facilitating emotional regulation and self-awareness;
- building self-esteem, self-acceptance, and confidence;
- stimulating a positive emotional response and improving mood;
- providing psychological support, for example related to bereavement or trauma;

Neurological
- Engaging auditory, cognitive, motor and emotional processing;
- Preventing cognitive decline and stimulating memory;
- improving attention and engagement in purposeful activities and occupations;

Communication
- Encouraging creativity and self-expression through verbal and non-verbal means, providing an alternative non-verbal communication channel
- stimulating and maintaining use of voice;

Social
- improving social inclusion and belonging, and reducing loneliness;
- increasing opportunities for meaningful socialisation and interpersonal interaction;

Sensory

- facilitating multisensory experiences;

Physical

- The arts, especially music, stimulate engagement in movement activities and dance, which can help to support and maintain physical mobility, and therefore prevent frailty, improve strength and flexibility, and reduce risk of falls;
- The manipulation of instruments and arts materials can support fine and gross motor skills;
- Engagement in the arts can help to increase levels of general daily activity, and has been shown to support pain management.

Appendix 3: Case Studies

Dietetics
Care Home menus should meet the Public Health Agency Nutritional Guidelines and Menu Checklist for Nursing and residential Homes. This ensures nutritional adequacy of meals and snacks offered to residents.
Intervention
The Care Home Dietitian supported 43 Nursing Homes to review and improve their menu and snack trolleys provision to meet this guidance.
Actions and Outcomes
Actions: • Observational audits were completed to review the provision of snacks mid-morning and afternoon. • Feedback to Care Home manager and Chef on audit • Menu planning sessions held with Chef and menus updated • Repeat audit **Outcomes:** • Greater variety in choice available for main meal and snacks • Improved nutritional adequacy of menus offered to residents • Compliance with the PHA guidance increased from 89% to 99%. • Snack trolley audits have been completed for 25 Nursing Homes. Compliance with recommended snack provision has increased from 86% to 100%. • Feedback from home chef*: **"Very educational and beneficial, looking forward to making progress and learning more"*** • Feedback from home manager: ***"Very good session, learned a lot"***

Dietetics
Care Home residents are often prescribed Oral Nutritional Supplements (ONS) to prevent and treat malnutrition. Supplement prescribing costs are high. Food First should be the first line approach.
Intervention
The Care Home Dietitian introduced trial provision of fortified milkshake drinks to replace or reduce ONS in Care Home.
Actions and Outcomes
Actions: • Fortified milkshake recipes were produced collaboratively with Chef • Review of residents to identify who was suitable to replace ONS with fortified milkshake • Training sessions provided to Care Home staff • Compliance audited • Review of residents clinical status completed **Outcomes:** • 67% residents maintained their nutritional status during trial • 45% reduction in ONS – cost saving over 2 months in 1 care home = £2126.

Potential GP prescribing savings per home over £12K per annum.

- Feedback from home manager after 1 month of project: ***"we have done our weights and we are so excited to see you – it is great news!" "the residents are really enjoying fortified drinks particularly Oreo® biscuit"***

Occupational Therapy
Resident had a previous Stroke. Client had been immobile but able to sit up daily on chair previously provided by OT. Subsequently client was unwell with Covid and on bed rest. Became 'bed bound' for several months with mood affected and becoming socially isolated.
Service
The Care Home OT Advanced Practice Role was set up as part of a Covid response
Intervention
Nursing staff were keen for client to sit up on specialised chair again however did not feel that the resident was safe to be hoisted. OT assessed clients overall functional ability and manual handling needs. OT identified that if staff explained everything in stages, had a slow and gentle approach and used a full body hoist sling, that the client complied well with hoisting into the chair and could tolerate sitting out for short periods. OT provided education to staff around the client's symptoms and how this had affected their physical ability, perception and understanding. OT provided education to staff around appropriate use of slings. Resident has since been successfully sitting up daily for several weeks and their mood has improved.
Actions and Outcomes
Functional assessment / manual handling needs reviewed to help facilitate resident sitting in specialist chair. Clients daily activities reviewed. Quality of life / mood improved according to subjective reports from staff and client / family. Clients manual handling care plans updated. Reduction in potential falls / risk of injury as client now being moved and handled appropriately. Quality of Life improvement for Client

Occupational Therapy
Resident who had a previous Stroke resulting in receptive and expressive dysphasia, reduced safety awareness, reduced functional ability and increased falls.
Intervention
Care Homes OT received a referral in relation to increased falls risk and manual handling needs. A functional OT Assessment was carried out of the clients transfer ability and functional mobility. The assessment incorporated safety issues.

The OT provided advice and education to nursing staff regarding management of clients symptoms and that quality of movement is much more important than quantity Recommendations were made about the environment layout OT identified that clients communication was very limited and that they could not express their wishes which was resulting in increased risk of falls when mobilising. OT advised a communication book provided by his Speech Therapist.
Actions and Outcomes
Falls and injury risk reduced Increased awareness of communication needs – Signposting to Speech and Language therapy Staff increased awareness of symptom management Client improved quality of life

Speech and Language Therapy
Resident was deteriorating and struggling with modified diet and fluids; staff requested swallow assessment and a clear plan
Intervention
Assessment revealed a very impaired, fatiguing, and overall, variable swallow. Already taking modified fluids and a maximally modified diet the resident was at high risk of choking and aspiration SLT discussed with GP and explained that resident was frail. The resident's pleasure from food was emphasised and the GP agreed that risk feeding was the best management path. Feeding with acknowledged risk of aspiration is always an MDT decision. This was discussed with staff and the resident's next of kin. During a sensitive conversation it was agreed that the resident should continue to be assisted with food and fluids, stopping if they became distressed.
Actions and Outcomes
SLT discussed and wrote up plan with staff to continue assisting resident with oral intake, stopping if the resident became distressed, and then returning to oral intake as wanted and tolerated.

Physiotherapy in partnership with wider AHP team
Physiotherapy in conjunction with other AHPs targeted specific care homes which had either: • High numbers of Covid positive patients during surge 1 of the pandemic and had needed a lot of support • Referred high number of clients to core AHP services
Intervention
. Physiotherapy interventions included individual assessments of residents to include manual handling assessment, falls risk and mobility assessments.

Interventions to individual residents included:

- Provision and replacement of equipment
- Exercise prescription to manage muscle weakness
- Falls prevention strength and balance programmes
- Mobility training
- Postural management for contractures and abnormal tone

AHP Multidisciplinary working included:

- Joint assessments with other AHPs e.g. OT for postural management regarding seating and physical management of increased tone
- Discussion with other AHPS regarding signposting for residents who needed onward referral to ensure appropriate and timely interventions
- Joint education sessions with other AHPS to care staff

Care home staff interventions:

- One to one working with care home staff to educate regarding specifics for individual residents, emphasising the need to incorporate physical activity as possible to improve physical ability
- Working with care home activity co-ordinators to implement and further develop exercise programmes
- Listening to care home staff to identify their issues and what would help to improve resident outcomes

Actions and Outcomes

For individual clients:

- Comprehensive physiotherapy assessment
- Equipment - ensuring safe and effective
- Improved physical functioning and reduced falls risk
- Management of tonal problems in keeping with NICE guidelines

AHP Multidisciplinary working included:

- Joint assessments provide improved experience for client with joint problem solving and reduces duplication
- Improved timely and appropriate onward referrals
- Professions complimenting each others roles and also improved understanding of the different roles for all

Care home staff interventions:

- Increased education and understanding for care home staff regarding manual handling, falls prevention and mobility recommendations
- Empowerment of care home staff to make decisions that will improve the life of the residents e.g - little and often for mobility if fatigue an issue, using Sara stedy as a standing aid if patient able to stand for some activities as well as using it for transfer aid
- Improved understanding of falls prevention strategies
- Ongoing engagement by physiotherapy staff with care home staff gives the opportunity to support further to develop their skills e.g. specific manual handling skills

Overall:

- Improved physical outcomes and quality of care for clients
- Improved communication and collaboration within AHP team and care home team
- Savings as inappropriate referrals reduced

- Savings as service duplication reduced
- Improved service to residents where joint assessment instead of multiple assessments by individual professions

Podiatry and the diabetes foot care pathway
Diabetes foot care pathway and application for care homes
Intervention
Podiatry as a profession can use the Diabetes foot pathway for resident in care home. Podiatry use direct referral via the pathway to ensure prompt access to appropriate care, particularly those at risk with active foot ulceration Podiatrists help manage the most complex active risk limb in conjunction with care home staff, other AHP/HCP, GP and multidisciplinary diabetes foot teams (MDFT) based in RVH and regional enhanced foot protection teams(EFPT) in acute hospital around the region
Actions and Outcomes
Actions: Diabetes foot pathway allows patient with active foot ulceration to move up and down the pathway as needed from the Foot protection teams based in community clinic who interact with care homes to EFPT and/or MDFT Right care and opinion promptly for those patients with diabetes and active foot ulceration whom may be at risk of limb loss and sepsis. Outcomes: • Can phone/ refer patients directly to EFPT/MDFT as needed for patients and start discussion re care with care home, GP and if needed liaised with member of Care home support • Use of Photograph to triage patient with MDFT/EFPT in the region as appropriate to the pathway and ensures that patient care is timely and appropriate • Education on diabetes and implication to foot health for staff ensuring best care for complex patient in care home with diabetes and active foot ulceration. • Wound care advice as well as appropriate debridement by Podiatry • Be the point of knowledge, expertise and referral for patients who need escalated up the pathway, EFPT/MDFT teams, other AHP/care home support team, GP on the risk to the foot and best care plan going forward. • This may be a huddle discussion with MDFT/EFPT on best care outcomes, may not always require a hospital visit dependant on patient situation and care needs. • Palliative/Conservative management may be an option but always discussed and agreed.

Multidisciplinary team which included AHPs

A care home resident had demonstrated functional decline over a period of time. This resident had been referred to the core services for review however the care home staff were concerned and made a referral to the GP and care home multidisciplinary team for more prompt assessment. The resident had ongoing deterioration and had attended ED twice in the previous month for recurrent falls and urinary tract infection and also for possible aspiration and shortness of breath. The resident also contracted COVID 19 during this period.

The care home nurse triaged this referral and identified areas of need:-

- poor swallow
- poor nutritional intake - MUST score of 3
- medication issues
- functional decline
- mobility issues

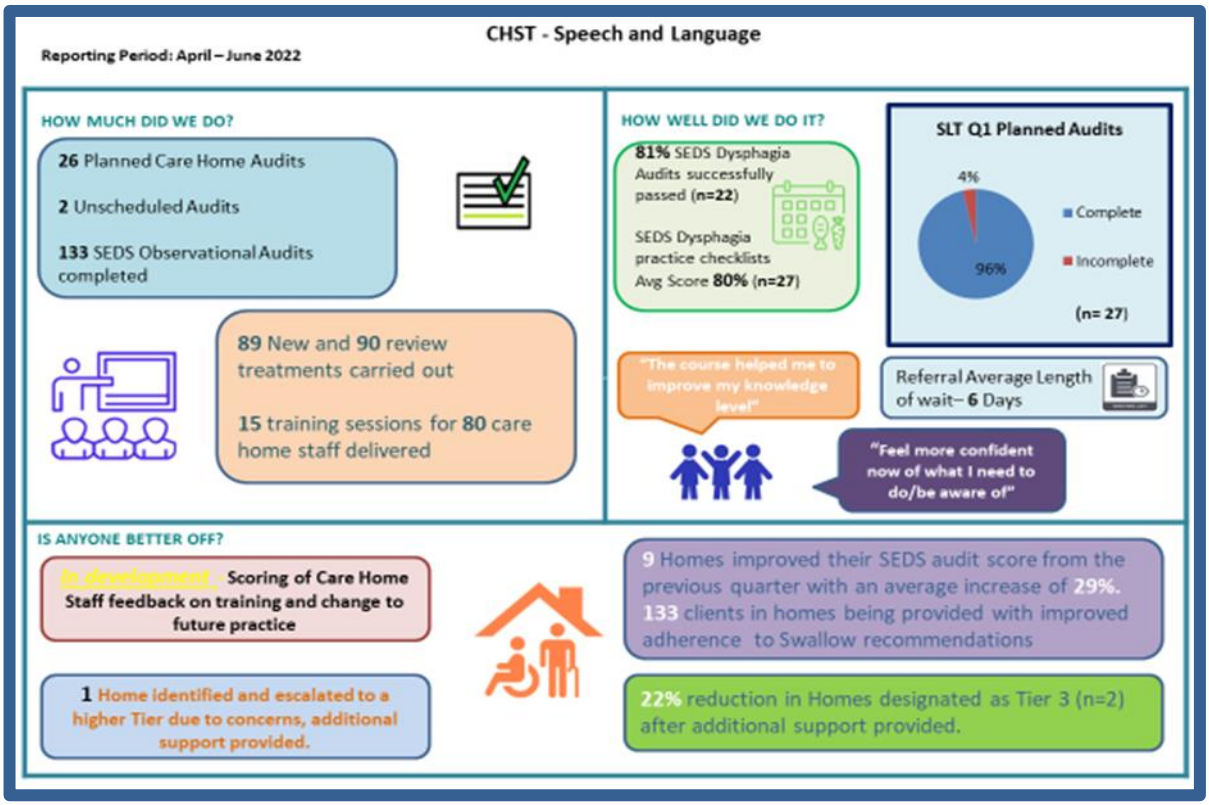
The priority need was identified at the multi-disciplinary team meeting and it was agreed that Speech and Language Therapy would assess this resident initially as this posed the greatest clinical risk to the resident. Within 24 hrs the residents swallow was stabilised and recommendations put in place. Subsequently assessment by the dietitian was undertaken invoking a recommendation for regular supplements and high calorie and protein dietary advice in line with SALT. Pharmacy also reviewed the resident's medication and all medications were altered to liquids to aid compliance and administration.

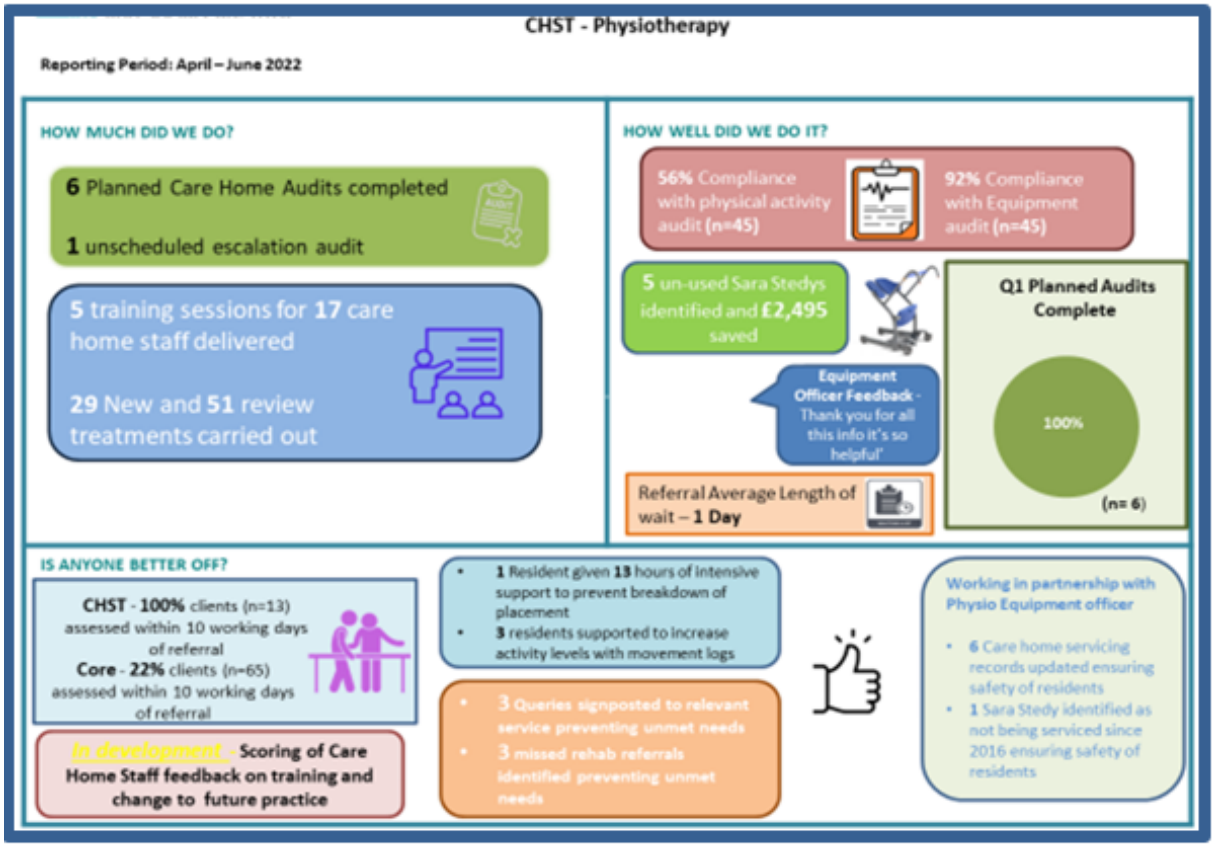
Thereafter the overall improvement in the resident's physical health (linked directly to the dietetic and SALT input) enabled the resident's functional ability to have a joint assessment by the OT and Physio. This led to the issuing of a new seating system and wheelchair from the OT as the resident was previously nursed in bed since admission to the care home. The physio was also able to work with the resident to improve their strength and capacity to sit out during the day. The resident was now able to engage with chair exercises and standing practice with the aid of a Zimmer frame and begin to walk short distances.

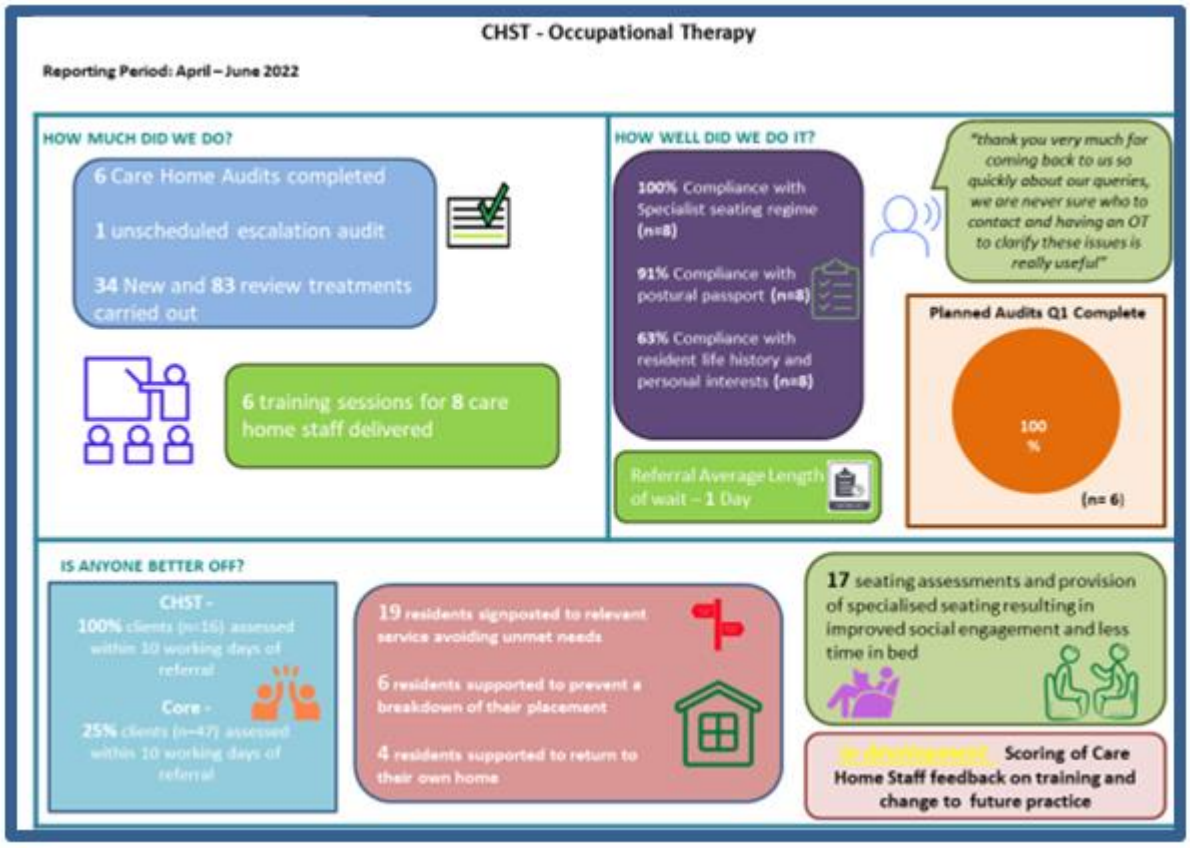
In summary this resident's improvement in overall functional ability through the continued engagement with the care home team was positive and the resident showed an increasing alertness and interaction with staff and family. The resident was now able to sit out in a wheelchair and the ability to use the wheelchair allowed for an improved quality of life and family engagement. Continued review and therapy will proceed to the goal of reduced or eliminated need for specialist seating and improved transferring abilities.

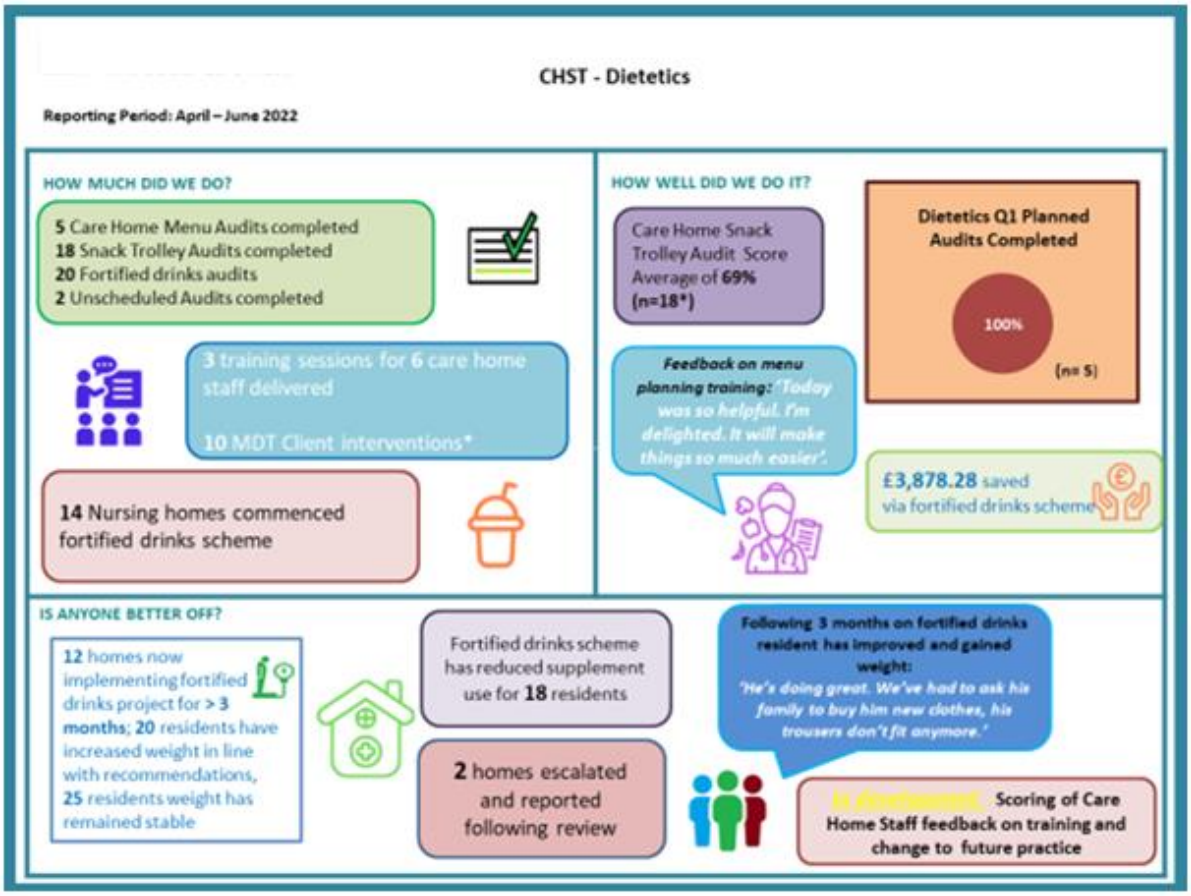
The prompt and multi-professional input for this resident shows that the most effective resource was utilised initially but in conjunction with the appropriately timetabled interventions from the additional professionals. The close working arrangement of the care home team and shared roles and professional collaboration but also autonomy allowed for a very responsive intervention model for this resident.

Appendix 4: “Score Cards” AHP Care Home Support Team






CHST - Occupational Therapy
Reporting Period: April – June 2022
HOW MUCH DID WE DO?
6 Care Home Audits completed
1 unscheduled escalation audit
34 New and 83 review treatments carried out
6 training sessions for 8 care home staff delivered
HOW WELL DID WE DO IT?
100% Compliance with Specialist seating regime (n=8)
91% Compliance with postural passport (n=8)
63% Compliance with resident life history and personal interests (n=8)
Referral Average Length of wait – 1 Day
"thank you very much for coming back to us so quickly about our queries, we are never sure who to contact and having an OT to clarify these issues is really useful"
Planned Audits Q1 Complete
100 %
(n= 6)
IS ANYONE BETTER OFF?
CHST -
100% clients (n=16) assessed within 10 working days of referral
Core -
25% clients (n=47) assessed within 10 working days of referral
19 residents signposted to relevant service avoiding unmet needs
6 residents supported to prevent a breakdown of their placement
4 residents supported to return to their own home
17 seating assessments and provision of specialised seating resulting in improved social engagement and less time in bed
In development Scoring of Care Home Staff feedback on training and change to future practice


CHST - Dietetics
Reporting Period: April – June 2022
HOW MUCH DID WE DO?
5 Care Home Menu Audits completed
18 Snack Trolley Audits completed
20 Fortified drinks audits
2 Unscheduled Audits completed
3 training sessions for 6 care home staff delivered
10 MDT Client interventions*
14 Nursing homes commenced fortified drinks scheme
HOW WELL DID WE DO IT?
Care Home Snack Trolley Audit Score Average of 69% (n=18*)
Feedback on menu planning training: 'Today was so helpful. I'm delighted. It will make things so much easier'.
Dietetics Q1 Planned Audits Completed
100%
(n= 5)
£3,878.28 saved via fortified drinks scheme
IS ANYONE BETTER OFF?
12 homes now implementing fortified drinks project for > 3 months; 20 residents have increased weight in line with recommendations, 25 residents weight has remained stable
Fortified drinks scheme has reduced supplement use for 18 residents
2 homes escalated and reported following review
Following 3 months on fortified drinks resident has improved and gained weight:
'He's doing great. We've had to ask his family to buy him new clothes, his trousers don't fit anymore.'
In development Scoring of Care Home Staff feedback on training and change to future practice

Appendix 5: Quantitative activity data on referrals into core AHP service

In order to understand the requirement for input for care home residents from core AHP services, data was gathered from Trusts over a one-year period, from 2019-2020, and is outlined in figure 1 below. As previously indicated this data collection was challenging, for some Trusts in particular, and so there is a risk that it is not entirely accurate. It is considered that referrals are higher than these figures show as it is recognised that some data is missing. The data collected does however give a general overview of core AHP services activity with care home residents and allowed the task and finish group enough information to help identify themes and make recommendation.

Data was also gathered from AHP Waiting Time returns from HSC Trusts to HSCB, as Trusts were unable to isolate data on waiting times for care home residents. In order to give a regional overview of waiting times, data was taken from the DoH HSC AHP Services Information Briefing Dashboard, with the source of the AHP information on this dashboard being AHP Waiting Time returns from HSC Trusts to HSCB. Data is collected on elective referrals to AHP services received for community and out-patients that require a booked appointment and which are not already open/active. Data is also collected on the number of patients waiting to be seen (at month end) by AHP profession and are subject to the Ministerial target that no patient should wait longer than thirteen weeks from referral to commencement of AHP treatment. These figures include those for care home residents although it was not possible to isolate out the specific data on care home residents. This gives a high-level regional picture of waiting times for elective referrals into core AHP services. Waiting time data was taken from the month ending March 2020 as this was the year data was collected from Trusts on number of AHP referrals for care home residents. Waiting List information is based on active waits as at the month end position and is a snapshot figure. This is a snapshot of numbers waiting at that date for elective AHP service from across Dietetics, Occupational Therapy, Physiotherapy, Podiatry and Speech and Language therapy

The figures illustrate:

- The number of referrals for care home residents to core AHP services across the region in one year. However, this is based on Trust returns which had gaps due to IT limitations and so there will be an underrepresentation of referrals. Figure 1 illustrates the number of referrals from Trust returns and the narrative describes how many Trusts were able to provide data for each profession in order to allow the reader to also see the underrepresentation.
- Figures 2, 3 and 4 provide waiting time information on core elective AHP referrals. This information includes referrals from all sources and across all programmes of care and so is much wider than that of care homes. It does however indicate waiting times for core AHP services and care home residents are subject to the same waiting times as others. The time a patient waits will be determined by whether the referral is triaged as urgent or routine, with urgent referrals expected to be seen within 10 days.

Figure 1 below shows the numbers of referrals into these five AHP professions for care home residents across one year, with the total number of referrals across all the professions being 14, 290. The figures are based on Trust returns with the understanding that not all Trusts were able to isolate this data. Therefore, it is assumed that the actual figure is higher. Occupational Therapy reflects figures returned from 3 Trusts and so the overall figure for 5 Trusts is assumed to be significantly higher. Dietetics reflects figures returned from 4 Trusts and so is also estimated to be higher. Physiotherapy reflects figures returned from 5 Trusts. Podiatry reflects figures returned from 4 Trusts and so is also estimated to be higher. Speech and Language Therapy reflects figures returned from 3 Trusts and so the overall figure for 5 Trusts is assumed to be significantly higher.

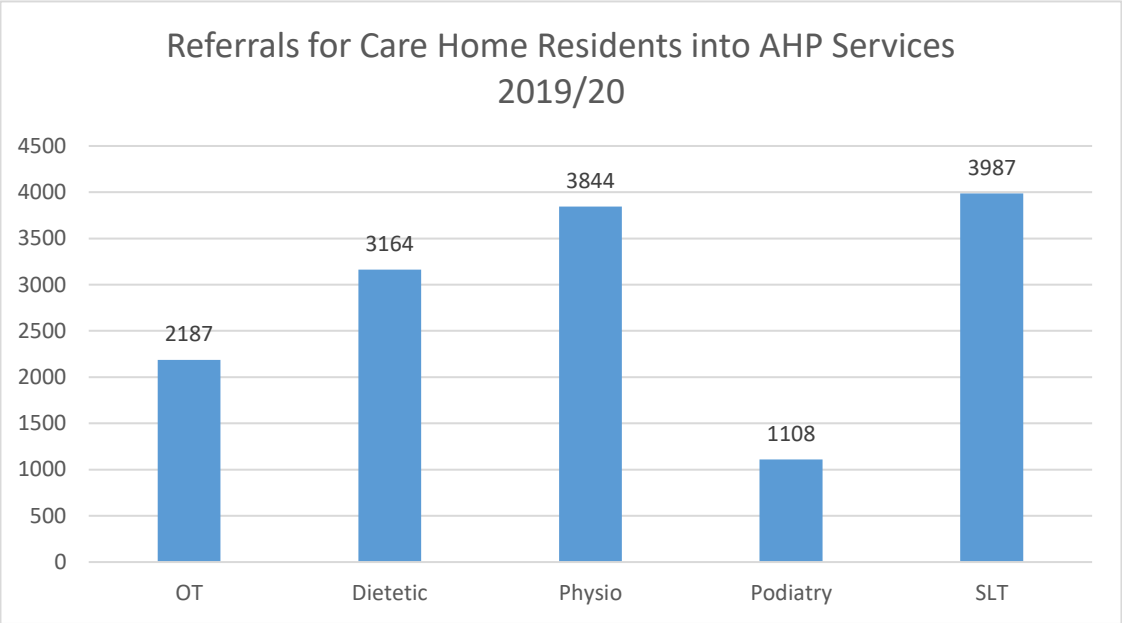


Figure 1: No of referrals for care home residents to the five core AHP services in 2019/20 (Source: Returns from HSC Trusts to Chair of Task and Finish group on referrals into core AHP services for care home residents-gathered on agreed template specifically for this task and finish work)

Figure 2 below shows the total number waiting for first AHP appointment by profession across the region as at month ending 31st March 2020. As previously highlighted these waiting time figures are for elective referrals received for community and out-patients that require a booked appointment and include those for care home residents although it was not possible to isolate out the specific data on care home residents. The total waiting at 31st March 2020 for first AHP appointment for these five professions across the region is 62,884.

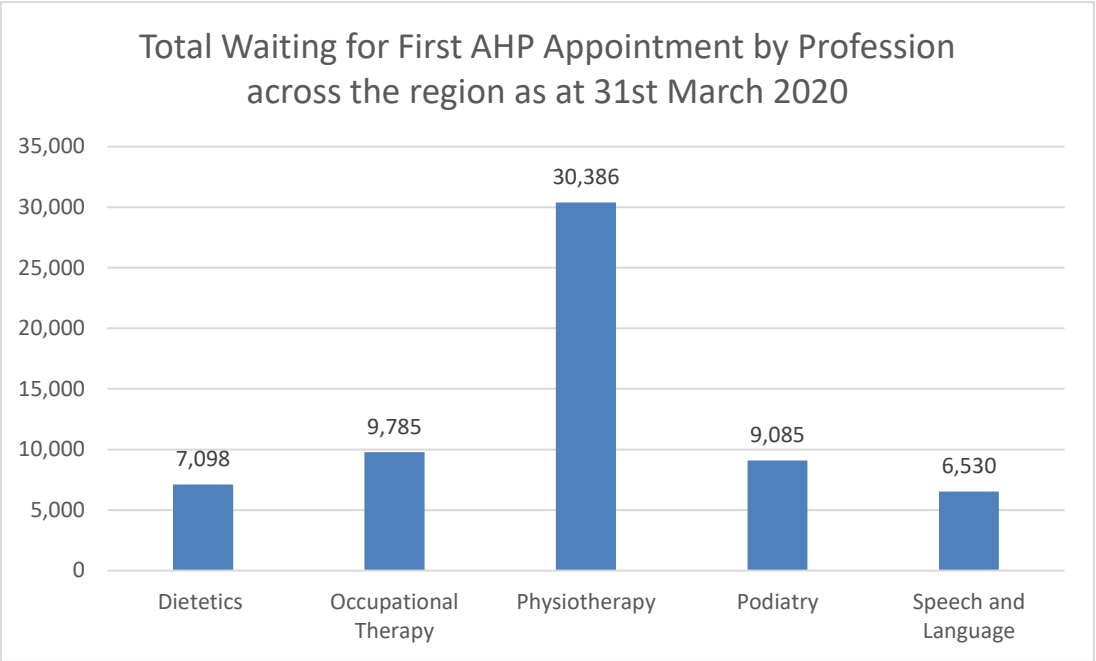


Figure 2: Total Waiting for First AHP Appointment by Profession across the region as at Month Ending 31st March 2020 (Source: AHP Waiting Time returns from HSC Trusts to HSCB)

Figure 3 shows the breakdown of those waiting more than 13 Weeks for first AHP appointment by profession across the region as at month ending 31 March 2020. The total waiting more than 13 weeks at 31st March 2020 for first AHP appointment for these five professions across the region is 18,584.

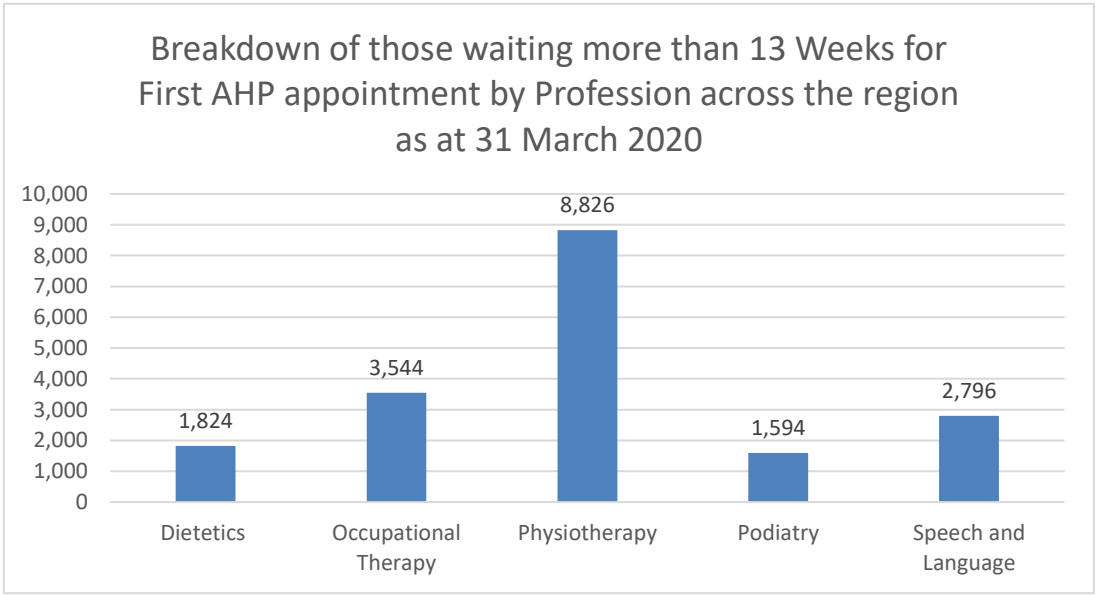


Figure 3: Breakdown of those waiting more than 13 Weeks for First AHP appointment by Profession at Month Ending 31 March 2020 (Source: AHP Waiting Time returns from HSC Trusts to HSCB)

Figure 4 shows the percentage breaching waiting time target of 13 weeks by profession across the region as at month ending 31 March 2020. This ranges from 18% of referrals for podiatry to 43% of referrals for Speech and Language Therapy breaching the 13 week waiting target.

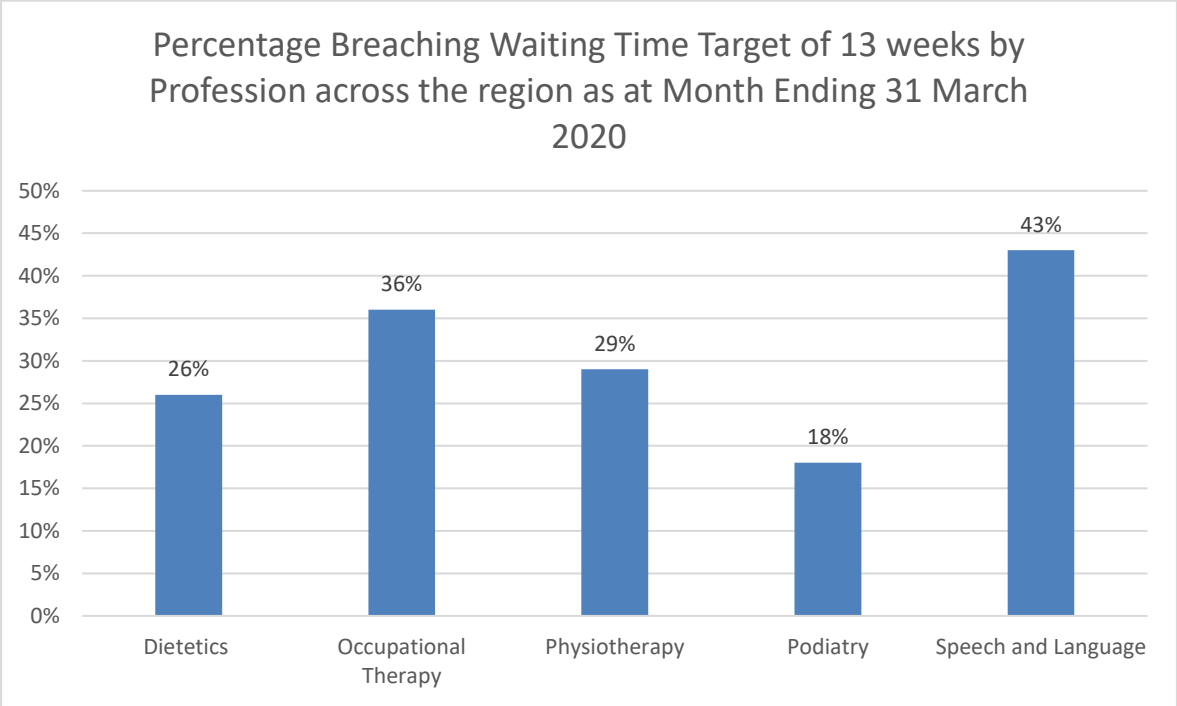


Figure 4: Percentage Breaching Waiting Time Target of 13 weeks by Profession across the region as at Month Ending 31 March 2020 (Source: AHP Waiting Time returns from HSC Trusts to HSCB)

Appendix 6: Quantitative data on referrals into a dedicated AHP service in a Care Home Support Team

In order to understand the responsiveness of the model where input for care home residents was from AHP services dedicated to care homes, data was captured over an 8-month period in 2021 from a Trust which had dedicated AHP input from Speech and Language Therapy and Occupational Therapy within its Care Home Support Team. As previously highlighted, this model of dedicated AHP input was only available in limited areas and so the data is not representative of entire professions or entire trusts. Rather it is to give a high-level picture of activity in terms of referrals and responsiveness when this model is available and when individual referrals are required.

It is recognised that teams which provided dedicated AHP input provide a whole home approach which works to reduce the need for individual referrals for specialist AHP intervention. Where individual referrals are required, some dedicated AHP services within care home response teams accept these referrals and some will signpost to core AHP service if intervention is required.

As with the model of input from core AHP services, the purpose of the data collected on this model was to give a general overview of AHP activity with care home residents from AHPs dedicated to care homes and allowed the task and finish group enough information to help identify themes and make recommendation.

An example of how responsive AHP services can be when included within a Care Home Support Team was shown by Belfast Trust Care Home Support Team. Data was provided for 8 months in 2021 from Speech and Language Therapy (SLT) and Occupational Therapy (OT) activity and this is shown here in figures 5 and 6. Referral numbers are low and this fits with the description of AHP care home support teams offering a whole home approach.

Figure 5, in relation to Speech and Language Therapy within the Care Home Support team, data showed that there were a small number of individual referrals per month into the SLT service, with 24 in total over 8 months. There were no individual referrals to SLT in April, May, or November. The response time varied per month with a longest average wait of 3 weeks and a shortest average wait of one day.

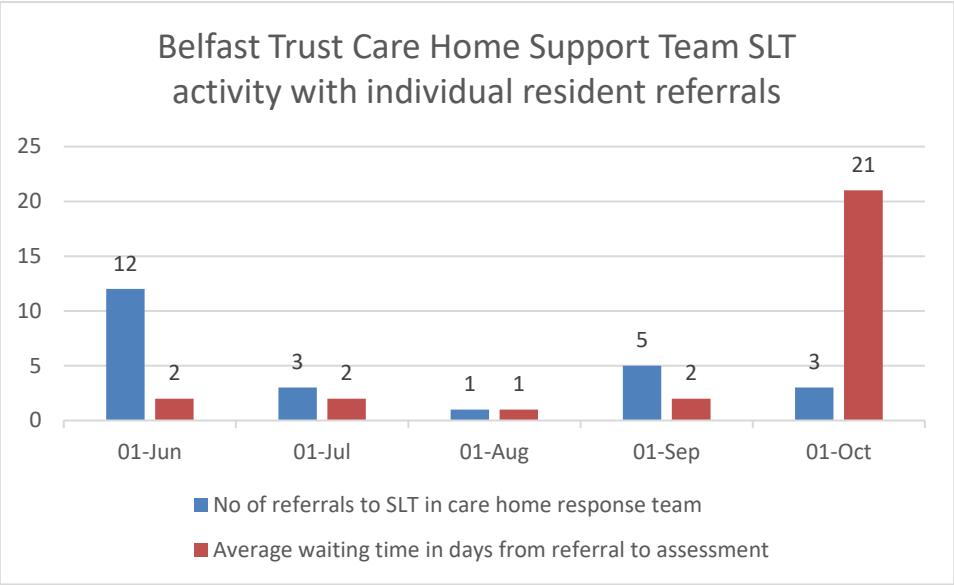


Figure 5: Belfast Trust Care Home Support Team SLT activity with individual resident referrals from April-November 2021

Figure 6, in relation to Occupational Therapy, data showed that there were a small number of individual referrals per month into the OT service, 25 in total across 8 months. There was very little variation from month to month in terms of response time, with an average waiting time each month of 2 days.

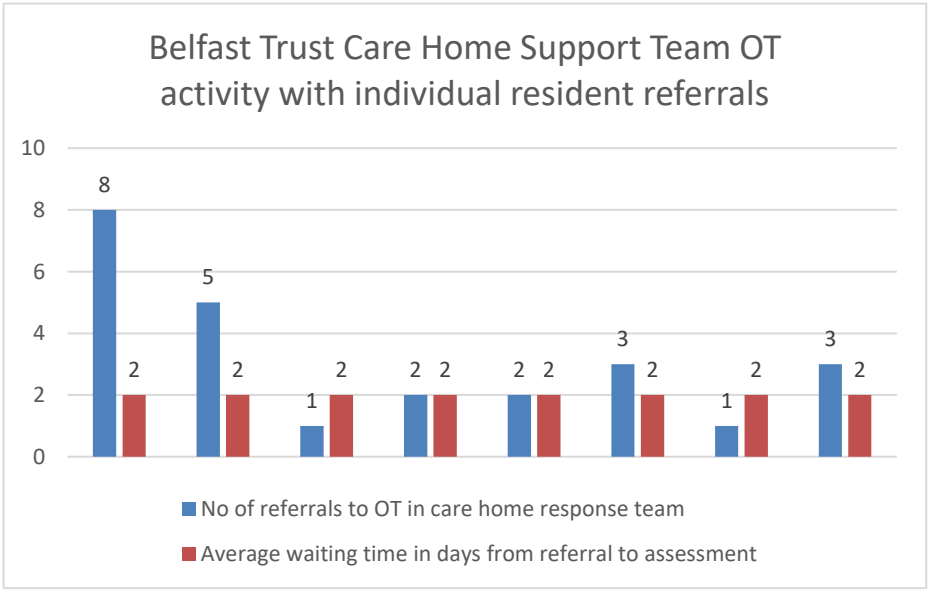


Figure 6: Belfast Trust Care Home Support Team OT activity with individual resident referrals from April-November 2021

Northern Health and Social Care Trust

Who are the Enhanced Care Response Teams?

East Antrim Pilot:

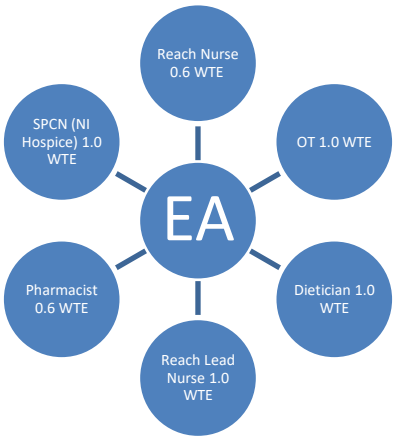
EA ECRT Jan 2021
Pilot commencement

Summer 2021
***Reduced WTE*:-**
SPCN
Clinical Psychology

Autumn 2021
***Reduced WTE*:-**
Frailty/ ACP Nurse

March 2022
***Reduced WTE*:-**
Physio
SLT

May 2022



Mid Ulster Pilot:

Mid Ulster ECRT Nov 2021
Pilot commencement

March 2022
***Reduced WTE*:-**
SLT

May 2022

REACH evaluation, 2022

Brief summary of some ECRT outcomes (REACH evaluation, 2022)

Outcomes showed:

- 3 Pilot Care Homes in East Antrim during a 15 month period had shown 92 less resident attendances to ED over the same period in the previous year (28%) reduction over a 15 month period
- Comparing 2021/22 with 2020/21, 6 further East Antrim pilot homes demonstrated 30 less resident attendances at ED over a 12 month period
- 2 Pilot care Homes in Mid-Ulster during a 5 month period showed 38 less resident attendances to ED compared to the same period in the previous year.
- All pilot homes experienced reduced resident ED attendances during implementation and interventions of the Enhanced Care Response Team.
- "The ECRT offers a timely response for residents in decline and those residents on core waiting lists who have a decline are also assessed and treated as appropriate impacting positively on core services**."**
- "The main objective of the enhanced care response team was to proactively assess and treat those residents within their preferred place of care in a timely way so to reduce any further clinical deterioration and potential unwarranted hospitalisation. To this end the service has been successful on so many quantitative and qualitative levels."
- The ECRT evaluation can conclude there is strong association between the input from the ECRT into care homes and their reduced resident ED attendance, thereby creating a huge potential to release capacity within the Emergency Department – a critical factor which clearly reflects and contributes strategically with the government agenda to reform Urgent and Emergency Care."

REACH, 2022

Appendix 8: Findings from engagement with four care homes and AHP and Nursing staff across core AHP services and ECRT to seek views on and compare the two models

Findings from engagement with the two homes which referred into AHP service dedicated to Enhanced Care Response Team (ECRT)

- **The referral process and ease of same**

- Both homes reported that referral form was sent via email to ECRT and that it was quick and easy
- One home noted that it was also easy to have a discussion with one of the multidisciplinary ECRT team to get advice on whether a referral was needed

- **Waiting time from individual referral to assessment when required**

- Both homes reported that waiting time from individual referral to assessment, when required, was no more than a week,
- One stated that it would usually be 2-3 days and the next day if urgent.

- **Views on partnership approach between AHPs and care home staff**

- Both homes reported that the partnership approach was strong between AHPs and care home staff
- Both homes reported having good relationships with AHP staff
- Both reported that it was very valuable knowing the AHP staff and residents having continuity of care from the same person
- One reported that it "was great being able to pick up the phone" for advice
- One reported that it was easy to have a discussion if there was a concern
- One reported the strong partnership working with the Activity Coordinator

- **Impact of AHP services for residents**

- Both homes reported that AHP services improved residents' quality of life, with one stating that this was related to intervention taking place sooner
- Both homes reported benefits for residents' families, with one stating that families felt involved and informed and the other stated families were "happy with speed of response"
- One reported that social isolation improved for residents as well as independence, mobility, physical health and appetite
- One reported that knowing who to contact improved time management for care homes and this impacted on their time with residents

- **Training or advice provided from AHP staff**

- Both homes reported that training was provided by AHP staff and that this was helpful. It was reported that training included dysphagia awareness; malnutrition, dehydration and food fortification; understanding dementia and changes in behaviour; occupational therapy overview on seating and pressure; physiotherapy training on use of mobility aids and promoting staff to assist with ongoing rehabilitation.
- Both homes reported that staff felt more confident after training, with one stating that it helped when talking to families as they could reassure them and one stating that staff felt empowered to ask questions because they knew the team members
- One home stated that it was useful knowing the AHP staff and being able to approach for ongoing advice
- One home stated that the training was very inclusive, with all care home staff involved and feeling valued
- Both homes stated that regular refresher training would be helpful so that it is available to all staff, including new staff joining
- One home stated that it was helpful that the training was focused on care homes

- **Satisfaction with service and suggestions for improvement**

- Both homes reported being satisfied with the AHP service
- Both homes reported that the service was more responsive than when referring into core AHP services
- One reported the benefits of knowing the team and the team knowing the residents and families of residents
- One reported the benefits of the AHPs dedicated to working with the care home contacting core AHP services when needed and how this improved time management for care home staff
- One reported the benefits of the AHP services being tailored to care homes
- One suggestion for improvement was that the pilot service of having AHP services dedicated for care homes was brought back

Findings from engagement with the two homes which referred into core AHP services

- **The referral process and ease of same**

- Both homes reported that the referral process was time consuming, with forms tending to be paper based and requiring to be posted and with a number of different forms used across the AHP services
- One reported that some referrals need to go through the GP rather than directly from the home which added to the time taken and that this caused nurses in the home to feel deskilled

- **Waiting time from individual referral to assessment when required**

- One home reported normal waiting times of between 2-7 months, depending on the individual profession and the urgency of the referral
- The second home reported normal waiting times of between 3-12 months, depending on the individual profession and noted that they had received notification from one AHP service that the wait was likely to be 24months
- Both reported that urgent referrals would typically be seen within 7-10 days

- **Views on partnership approach between AHPs and care home staff**

- One home reported that the partnership approach is helped if the AHP is known to the care home staff and that they sometimes are
- The other home stated that there is no partnership approach as "there is not much capacity" and that the system did not facilitate partnership, with the care home not knowing the individual AHPs
- One home reported that any engagement with AHP services is in relation to a specific resident and not a general home enquiry

- **Impact of AHP services for residents**

- Both homes reported that AHP services have a big impact on residents, improving quality of life
- However, both homes reported that long waiting times impact adversely on the residents

- **Training or advice provided from AHP staff**

- Both homes reported that no specific training is provided, except for any which is available online, eg dysphagia awareness
- One home reported that advice is limited to individual residents once they are referred

- **Satisfaction with service and suggestions for improvement**

- One home stated that the AHP services are "exceptional... when you get it" but that "time frames are long"
- The same home reported that they get no feedback following the referral until the point of assessment, which can be a considerable wait, and that this is "frustrating"
- Similarly, the second home stated that "When you get it it's great, time frames are poor"
- The second home also reported lack of partnership working, with no training or education provided.
- Suggestions for improvement from across the two homes were reducing waiting times; making referral documentation easier; having tailored training; better partnership working; having a named point of contact; having online referral and email contact to allow access to timely advice and having generic referral forms

➢

Findings from engagement with AHP and Nursing staff in ECRT and AHPs in core AHP services

- **The referral process and ease of same**

➢ When referrals are made into AHP services in ECRT
  - they come into a controlled email address and these are triaged, once triaged they are sent out to the professions who need to be involved
  - focus group all agreed that the referral process into ECRT is easy and that the triage helps with understanding roles and teamworking

➢ When referrals are made into core AHP services
  - the process varied across professions and often involved posting hard copies
  - there can be multiple referral forms for one resident which are then sent to multiple services and all have different referral pathways

- **Waiting time from individual referral to assessment when required**

➢ When input is from dedicated AHP service within ECRT
  - the waiting time for individual assessment, when required, is typically between 2-14 days and there is variation within this across the professions. However, it was noted that this model mainly focuses on a whole home approach reducing the need for individual referrals. Therefore this is the typical timeframe when a referral is still required

➢ When input is from core AHP services
  - the waiting time is influenced by whether it is an urgent or routine referral. It was reported that on average urgent referrals are seen within 2-3 weeks and routine referrals seen usually within 13 weeks. However, one profession noted that their waiting time is currently up to a year and another profession stated their waiting time is up to 2 years

- **Views on partnership approach between AHPs and care home staff**

➢ When input is from dedicated AHP service within ECRT
  - partnership approach is working very well with good rapport between AHP and care home staff
  - relationships benefit from continuity and staff knowing each other
  - overall good feedback on face-to-face approach

➢ When input is from core AHP services

- there is a very limited partnership approach with no capacity for training or "getting to know staff"

- **Impact of AHP services for residents**

➢ When input is from dedicated AHP service in ECRT
  - Care home staff are trained in AHP approaches and this improves the ethos for the entire home
  - The whole home approach helps to prevent deterioration of residents
  - There is a holistic and integrated approach with the resident with the multidisciplinary team working together and agreeing who needs to see the resident and when in order to improve outcomes
  - Residents are seen more promptly when individual assessment is needed

➢ When input is from core AHP services
  - Individual residents benefit from AHP services following referral and assessment

- **Training or advice provided from AHP staff**

➢ When input is from dedicated AHP service within ECRT
  - training is provided and staff report feedback is very positive from residents and staff
  - it was reported that care home staff said they felt more empowered and listened to
  - it was stated that care homes said they preferred when training was face to face
  - it was reported that care homes said they preferred when training was bespoke to care homes rather than generic

➢ When input is from core AHP services
  - there isn't capacity for training with any home advice usually being in the form of leaflets other than advice for individual residents

- **Satisfaction with service and suggestions for improvement**

➢ When input is from dedicated AHP service within ECRT
  - there was great satisfaction with collaborative and holistic approach for the residents
  - team reported feeling supported with good partnership working and teamwork
  - team had job satisfaction
  - team felt satisfied that they were able to provide timely assessments for residents
  - there is the advantage of having regular team meetings and case discussions. During the initial case discussion, the professional most relevant to the residents immediate clinical need is agreed as the key lead professional that undertook the

initial assessment visit. This allowed a more effective and efficient use of professional time and had greater immediate therapeutic benefit to the resident

- When input is from core AHP services
  - staff reported that better relationships are needed
  - better access is needed for residents
  - referral documents need streamlined
  - waiting times reported as too long