Reducing the pressure on hospitals

A report on the value of occupational therapy in NORTHERN IRELAND

College of Occupational Therapists

Occupational Therapy
Improving Lives
Saving Money
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No one wants to go into hospital. The reality is that too many are admitted unnecessarily.

During 2015–2016, occupational therapists gathered data to demonstrate exactly how their services enable more people to either avoid admission to hospital or return swiftly home. This report is the culmination of their work. Policy leads and managers of health, care, housing and other services cannot fail to find the contents useful and informative when developing or reviewing services.

The report details how occupational therapists can not only reduce unnecessary transfers into both A&E departments and admissions, but also ease the patient’s journey and ensure timely, appropriate and safe discharge home. Those that receive help from an occupational therapist prior to, or during, their stay in hospital have better outcomes and are unlikely to require rapid, costly and upsetting readmission.

Occupational therapists are unique in that they are trained to work within both health and social care settings, and across mental and physical health. This knowledge enables them to navigate care and support systems efficiently, liaise appropriately, and work effectively in multidisciplinary settings; they are the key workforce when it comes to reducing hospital-related pressures. Put simply, occupational therapists deal with many of the impediments that often prevent a safe, speedy and satisfactory discharge home. This report will tell you how.

Julia Scott
Chief Executive Officer, College of Occupational Therapists

“With A&E attendances increasing, the pressures on emergency departments are greater than ever before. Action must be taken to address demand and relieve pressure on A&Es. This report demonstrates the important part occupational therapists have to play in reducing pressures on primary care services alongside improving the overall quality of care that patients receive. I have been fortunate to work in a unit with front door occupational therapy seven days per week and so I am acutely aware of the benefits to the system that that brings.”

Dr. Sean McGovern, Vice President of the Royal College of Emergency Medicine Northern Ireland
Executive summary

The case for change
Based on service examples collected over a 12-month period, this report focuses on the value that occupational therapists are bringing to improve patient outcomes and maintain the flow of patients in and out of hospital. A key point to note is that investing in occupational therapy has the potential to improve care quality without increasing overall hospital spending.

The Health and Social Care (HSC) system in Northern Ireland is facing unprecedented demand and financial constraints. With 612,996 patients attending the 10 major accident and emergency (A&E/EEM) departments in Northern Ireland in 2015, the system is under continual and increasing pressure. ‘In 2015 just 77.5% of patients were treated within four hours – the worst performing of all the UK nations’1.

This report outlines the role occupational therapists can play in realising the vision of Transforming Your Care2 and achieving sustainability within services. From the College’s member survey, it is clear that 98% of occupational therapists are confident that they can play a key role in keeping people at home and avoid admission into hospital.

The recognition that early action, prevention of admission and an enabling or reabling approach can both improve people’s outcomes and save money, sits in perfect harmony with the philosophy and principles of occupational therapy. These principles are shared and sit at the very heart of Transforming Your Care3 in terms of placing the individual at the centre of the integrated care model; providing the right care in the right place at the right time; a focus on prevention; and promoting independence and personalisation of care.

Why occupational therapy?
The College of Occupational Therapists is calling on policy makers, commissioners and service providers to recognise the true value that occupational therapists can play in helping the health and care sector develop into a service that is both highly efficient and meets the needs of patients.

With continuing pressures on budgets, the HSC will struggle to make the efficiencies required if vulnerable people are not given the community support they need. People cannot move in and out of hospital based on health need alone unless there is appropriate care and support in their local areas.

To achieve integrated care pathway delivery models that focus on maintaining or regaining an individual’s independence, occupational therapists must be considered as a fundamental part of the solution to:

- Ensure a stronger emphasis on prevention and early intervention
- Reduce the need for hospital visits and admissions through delivering interventions in the home or community setting
- Embed self-management principles and ensure a person-centred ethos.

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1 Royal College of Emergency Medicine (2016) Essential facts regarding A&E services. Belfast: RCEM. Available at: https://portal.rcem.ac.uk/live/RCEM/News/News_2016/Essential_facts_regarding_A_E_services_launched_by_RCEM_Northern_Ireland.aspx?WebsiteKey=b36f2b2a-abb4-44ed-b75b-46776a9584dd
Recommendations

The College has focused its six key recommendations on how occupational therapists can enable appropriate ‘hospital flow’, highlighting the unique work and value that occupational therapists can bring to Health and Social Care (HSC). Given the role occupational therapy plays in improving peoples’ lives and enabling resources to be used effectively, the College urges stakeholders to reconsider the size, deployment and utilisation of this versatile workforce.

This report presents clear recommendations with strong supporting qualitative data, showing the beneficial impact occupational therapists are having on patient health experience and quality of life. Vitally, in a system that is struggling with its current financial settlement, this report demonstrates that occupational therapists make efficiency savings while improving the patient experience.

“Collective political leadership and a relentless focus on implementing change’ was the key message this year from the Northern Ireland Confederation for Health and Social Care (NICON). More people are living longer and many with complex health and care needs. We need services that better meet changing needs and to make sure they are sustainable in the longer term. A strategic approach to prevention and early intervention, taking steps to avoid unnecessary admissions to hospital for people who have no medical need to be there and supporting people to manage their conditions are essential. It is here that occupational therapists, working in partnership can play an essential role and are already taking a creative leadership position in developing solutions. This is a journey we will all need to embrace and I commend our occupational therapy colleagues for being at the forefront of this agenda.”

Heather Moorhead, Director, Northern Ireland Confederation for Health & Social Care.
The College calls on commissioners and service providers to adopt the following recommendations.

**Reducing admissions to hospital**

**Recommendation 1:**
To prevent falls-related admissions, there must be increased partnership working between occupational therapy services and ambulance services when responding to falls.

Rationale:
Occupational therapists are involved in supporting older people to avoid unplanned admissions into hospital by working in partnership with paramedics, responding and addressing issues related to falls – a primary reason for hospital admission among older people.

**Recommendation 2:**
All hospital at home schemes, rapid response and acute and emergency care services must have occupational therapists embedded within the multidisciplinary teams, and this includes ‘Home Treatment’ teams for mental health.

Rationale:
Occupational therapists involved directly with acute and emergency departments or as part of a hospital at home team, can reduce the need for admission on to hospital wards. Trained to assess a person’s cognitive, physical and functional abilities, occupational therapists can expedite safe discharges. Working across boundaries, occupational therapists can ensure care needs are appropriately highlighted to primary and community care services, freeing up capacity for acute and emergency services.

**Reducing time in hospital**

**Recommendation 3:**
To achieve optimum patient flow and fast-paced assessments, commissioners must include occupational therapy in funding for out of hours services.

Rationale:
Higher levels of people are discharged home where occupational therapists are working extended hours and seven days a week.

**Recommendation 4:**
All multidisciplinary admission and discharge teams across the hospital environment must include occupational therapists, with therapy-led discharge planning for people with complex health care needs.

Rationale:
Occupational therapists play a crucial role in achieving successful transitions between services.

**Successful transition and discharge**

**Recommendation 5:**
To ensure timely and successful discharge, commissioners and providers must support the development of therapy-led services.

Rationale:
Cheaper than the traditional medical model workforce, occupational therapists can make cost savings for services whilst improving outcomes for patients.

**Recommendation 6:**
Occupational therapy-led reablement services should expand to include all adults and provide a seven-day programme of care.

Rationale:
Reablement (enabling return to occupational abilities) reduces delayed discharge and untimely readmissions. Gold-standard community support must offer more than just a return to basic daily living activities, to ensure, improve and maintain a person’s overall health and wellbeing.

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Reducing admissions to hospital

With the unprecedented rising demands on hospitals in Northern Ireland, this report identifies how occupational therapists can reduce the pressure on urgent and emergency care pathways. Based on examples collected by the College of Occupational Therapists, this document focuses on the value that occupational therapists are bringing to improve patient outcomes and the flow of patients in and out of hospital.

With improvements in healthcare the number of people living with disease, often multi-morbidities, has increased immensely and people are living longer than in previous generations. The 20-year strategic framework for primary care Caring for people beyond tomorrow⁴, recognised the need for wider development of community-based alternatives to hospital admissions. Transforming your care⁶ built on those themes by aiming to shift service provision away from hospitals and towards care closer to where people live, with a focus on more personalised care, prevention and early intervention, and promotion of health and wellbeing.

Against a backdrop of financial restraint, the restructuring and reform of health and social care has been ongoing with the Donaldson Report⁷ and the expert panel led by Professor Bengoa. It is vital that the right workforce is in place to support a reshaped HSC. The planned vision for HSC resonates with the principles, values and approach of the occupational therapy profession.

Occupational therapists are active health enablers. They differ from other health professionals in that they do not try to fix or cure the medical problem but rather endeavour to fix ‘what matters to the person’, so that they can participate in the occupations they need, want or are expected to do.

Occupational therapists understand the significant impact that occupations and daily living routines have on peoples’ health and wellbeing. This approach enables people who are frail or who are living with chronic conditions to manage their health while continuing with daily life. Proactively supporting people in their communities helps to reduce costs associated with escalation of poor health as well as improving population health. Prevention is therefore key.

The prevention agenda

Recommendation 1: To prevent falls-related admissions, there must be increased partnership working between occupational therapy services and ambulance services in responding to emergency calls related to falls.

Too frequently in-hospital care is provided for patients who have no medical need to be there. To effectively address this, services should focus on reducing both initial admissions to hospital and readmissions of discharged patients. Occupational therapists work to achieve both. This report will highlight examples of how occupational therapists are delivering services to people at home in the community. Input is provided at both early intervention and preventative levels, and this aims to prevent avoidable episodes of care, help people self-manage their conditions and support independent living in daily occupations. For example, the Southern Trust Acute ‘Care at Home’ Team offers expert assessment and treatment enabling acutely ill patients to remain at home.

Southern Trust ‘Acute Care at Home’ Team

The Southern Trust Acute ‘Care at Home’ programme is a consultant-led community service to deliver acute, non-critical care in a community setting. It is available to patients over 65 in their own home, nursing or residential setting – most referrals are for patients with multiple co-morbidities.

There is a response target of two hours from referral to treatment, which provides rapid access to senior medical, nursing and allied health professional staff. Occupational therapists play a key role in the advanced assessment, treatment and clinical management of patients. They are able to provide urgent comprehensive assessments and can minimise the level of interruption to the person’s daily routines and environment, as well as educate staff, family and carers on how each person is best cared for, taking into consideration their daily activities and personal preferences.

⁶ Department of Health (2014) The right time, the right place. Belfast: Northern Ireland Government. Available at: https://www.health-ni.gov.uk/publications/right-time-right-place
Occupational therapists within the team can be first responders to crisis situations and they are able to carry out clinical observations and monitor vital signs. They have enhanced skills such as carrying out venepuncture. On the initial visit, they are able to carry out a full holistic assessment, which includes looking at functional abilities, cognitive abilities, falls risk and support networks. This information enables the doctors in the team to make an informed decision between maintenance at home or admission to hospital.

One of the key highlights mentioned in the Health and Social Care Board annual report and accounts for the period ended 31 March 2016 was in relation to the Acute Care at Home service. (The figure is inclusive of people seen in residential and nursing homes as well as their own home).

The team has been operational in the Craigavon district since September 2014 and has managed to assess and treat more than 770 older people with complex healthcare needs in their own home, either avoiding an admission to hospital or facilitating an early discharge.

“This service was exemplary. My family and I were most impressed by the co-ordinated approach to my mother’s care...”

“Equipment and support from occupational therapy helped with confidence and mobility issues. The attention we felt from the team was superior to the level of care mum would have received in a busy hospital ward. I could find no shortcomings in this service and could not recommend it highly enough. It is pleasing to see an initiative dedicated to care of the elderly. In a struggling NHS, this is healthcare at it’s very best” Feedback from a family member

“The experienced occupational therapists on the acute care at home team have played a pivotal role in the success of this service. Patients under the care of the acute care at home team are assessed by the occupational therapist on admission. This ensures that patients have a detailed assessment of functional ability, cognitive function, falls risk and social input. The occupational therapists on the team have an extended range of clinical skills which include venepuncture and clinical observations. The prompt intervention of occupational therapy ensures that a rehabilitation programme and increased social support can be initiated on admission thus avoiding the need for emergency department attendances or hospital admission. Patients on the acute care at home scheme have had excellent outcomes in terms of recovery of functional ability, low incidences of delirium and falls.”

Dr P McCaffrey, Consultant Geriatrician and Lead Consultant for the Acute Care at Home Service

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Falls are the most common cause of death from injury in the over 65s, making this a key area for prevention. Accounting for 40% of ambulance call-outs, falls are the single biggest reason for emergency hospital admissions for older people. Falls are also a key factor in older people moving into long-term nursing or residential care as they can no longer cope at home\(^9\). Health and social care expenditure relating to falls is considerable\(^{10}\).

Occupational therapists lead on falls prevention in older people in many UK services. This is because their skills in understanding the reasons for falls, looking at the person, environment and occupation, is coupled with them being best placed to address the identified needs. Evidence from the College of Occupational Therapists Falls guideline\(^{11}\) was used in the National Institute for Health and Care Excellence (NICE) quality standard Falls in older people: assessment after a fall and preventing further falls\(^{12}\).

Southern Trust, Acute Care at Home Programme

The Acute Care at Home Team (Southern Trust area) responded to an 87-year-old man who had fallen and been lying on the floor for 24 hours. A referral was received from the Northern Ireland Ambulance Service, and the gentleman had no fractures or injuries from the fall.

The occupational therapist, as first responder, carried out an initial visit to assess the gentleman’s functional abilities, pain level, and ability to manage daily activities safely within the home. She also completed clinical observations and obtained bloods. With this information she was able to feed back to the team and support the doctor in determining whether the patient could remain at home managing any risk safely.

The occupational therapist arranged for a family member to stay overnight, adapted the environment to enable accessible sleeping arrangements and provided adaptive equipment so personal care and activities of daily living could be carried out safely. She arranged for the removal of all falls risk factors within the home and a referral was completed for environmental adaptations to reduce risk of further falls. The patient received daily rehabilitation allowing him to regain functional independence within 5 days of treatment from the team. This occupational therapy intervention avoided hospital admission.

Falls prevention is a priority. In other parts of the UK, occupational therapists are involved in innovative care pathways to prevent unplanned hospital admissions due to falls. This includes working with ambulance services to triage and address patient needs more effectively once a person has requested urgent assistance.


In Lancashire, in the 12 months before January 2016, 78% of people who received an innovative joint assessment between a paramedic and an occupational therapist were able to remain at home. This partnership is called the Falls Response Service (FRS) and has been set up by East Lancashire NHS Hospitals Trust and North West Ambulance Service (NWAS). The FRS is sent out to 999/111 calls from people who have fallen but do not have an apparent injury as the multidisciplinary team is able to simultaneously check for health concerns that need immediate attention as well as assessing what caused the fall and establishing future prevention measures.

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This is a dramatic reduction from the previous rate of 70% of people being taken to hospital, as the FRS partnership conveys less than 23% of those it assesses. During the pilot period of January to September 2015 the FRS completed an average of three ten-hour shifts a week. The savings to the emergency department have been calculated at £27,000 based on 214 calls costing an average of £126 per incident. The pilot has now been made permanent.

There is a need for a fresh look at the prevention agenda as it is clear emergency departments are struggling under rising demand. To this end, occupational therapists recognise the need for increased partnership working between occupational therapy and ambulance services responding to emergency calls as a result of falls.

At the time of going to press, the Northern Ireland Audit Office (NIAO) is compiling a report, which will examine the increase and patterns of emergency admissions. The areas under scrutiny relate to occupational therapy practice i.e. self-care and signposting patients to services. It will also examine actions that have been taken to ensure that patients admitted as emergencies do not remain in hospital any longer than is necessary.

“With an ageing population there is a need for a real shift in how our health and social care services are provided. An emphasis on supporting older people who are frail or who have long term health conditions is essential but there must be focus on prevention, early intervention and enabling older people to remain active and independent. The default position shouldn’t mean older people just end up in hospital; reducing the need for hospital visits and avoiding unnecessary hospital admissions are where occupational therapists can play a critical role to ensure older people receive the right care, in the right place at the right time”.

Eddie Lynch, Northern Ireland Commissioner for Older People

What makes for a good service? Key factors for preventative partnership services:

Taking the person, the environment and the person's occupations into account, occupational therapists can minimise the risk of further falls and prevent unnecessary admission by:

- Assessing the home and advising on home modifications
- Addressing fear of falling
- Advising on how to incorporate activities to improve strength and balance into daily occupations and routine.

Inside the emergency department

Recommendation 2: All hospital at home schemes, rapid response and acute and emergency care services must have occupational therapists embedded within the multidisciplinary teams, and this includes 'Home Treatment' teams for mental health.

The total number of attendances at emergency departments in Northern Ireland since 2014/15 has increased by 3.7% – this this equates to an additional footfall of 27,434. Over the same time period performance against the 4-hour waiting times target worsened by 1.3 percentage points to only 76.2%. In addition, a higher number of patients waited longer than 12 hours in 2015/16 (3,875) compared with 2014/15 (3,170).

For occupational therapists to work effectively in A&E, timely access is vital. Attending an emergency department is associated with a high risk of admission for older people, who are admitted to hospital more frequently and then stay in hospital longer than other patients. Having occupational therapists at the front-door of A&E departments enables them to make rapid interventions to ensure that people are admitted to hospital only for urgent medical need.

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By looking at a person’s cognitive abilities, mobility and function combined with their past medical history and family, home
and social support available, occupational therapists can routinely recommend planned discharges based on a person’s ability
to engage with their daily occupations once back at home. This allows any ongoing care needs to be safely transferred back
into primary and community care, freeing up capacity for A&Es to deal with those patients with immediate need.

This method is not only better for the patient, but the efficiency savings speak for themselves. Where specialist occupational
therapists are embedded in A&E, frailty teams or rapid response teams there are reductions in unnecessary admissions.

**Occupational Therapy - Western Trust**

The Western Trust is comprised of two acute hospitals but the Multidisciplinary Assessment Team is only in place
within Altnagelvin Area Hospital. The team works within the Emergency Department but occupational therapy also
has a dedicated role within the Clinical Decision Unit and is responsible for supporting discharge within 24 hours,
where appropriate. The Multidisciplinary Assessment Team is made up of occupational therapists, social workers and
physiotherapists and many of the assessments involve collaborative working. The service is newly established and has been
in place within the Western Trust since 1 June 2016. Currently hours of operation are Monday to Friday, between the
hours of 09.00-17.00 with plans to implement on a seven-day basis in the near future.

**Patients assessed within the Emergency Department by occupational therapy**

A total of 109 patients seen by occupational therapy from 1 June – 31 August 2016. Of these:

- 26% (n=28) admitted to acute bed
- 70% (n=76) assessed by occupational therapy have been discharged home, of which: 5% of patients were discharged
to an alternative setting i.e. rehabilitation bed. 42% were referred onto a range of community services.

**Patients assessed within the Emergency Department and Clinical Decision Unit.**

A total of 85 patients seen by occupational therapy from 1st July – 31 August, 2016.

Of these:

- 31% of patients avoided admission to an acute bed.

This equates to 284 bed days saved costed at £300 per bed day = estimated cost saving of £85,200.

In June 2015, the Royal College of Emergency Medicine championed the call for A&E to be a hub, not a department, and
with provision of co-located primary care services such as Frailty Teams and Out of Hours Primary Care Teams\(^\text{15}\). Where
occupational therapists are working in such teams they are having a positive impact, regional examples are given, but this
needs to be adopted nationally to have true impact.

The inclusion of occupational therapy is not only better for the patient, but the efficiency savings can be clearly
demonstrated. Here are some of the many examples that show that where specialist occupational therapists are embedded
in A&E, Frailty Teams or Rapid Response Teams, there is reduction in unnecessary admissions.

In 2015, 2,463 patients were treated by a rapid response team of occupational therapists and physiotherapists in Barnet
Hospital’s A&E, 83% of whom were discharged directly from the emergency department. With the average length of stay
for patients admitted from Barnet Hospital A&E being 8–11 days, managing admissions appropriately clearly impacts on the
bed capacity in this local hospital.

Similarly an occupational therapy-led service based inside the emergency department at the Imperial College Healthcare NHS
Trust, saw a discharge rate of 79% per month, with 6% of patients discharged to rehabilitation or interim care. Only 13%
were found to need admittance based on medical need.

A rapid response multidisciplinary team, which includes occupational therapists, established in a community clinic in north
London saves approximately £1,800 per hospital admission it prevents. An A&E occupational therapy team working out

  Briefings/RCEM/Quality-Policy/Policy/Reports_and_Briefings.aspx?hkey=ed8bd32b-7c5e-42b6-80ac-d0e6c5cb3293

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The inclusion of occupational therapy is not only better for the patient, but the efficiency savings can be clearly demonstrated.

What makes for a good service? Key factors for A&E services:

• Occupational therapists directly involved in A&E services
• Open referral from all relevant sources and daily review by occupational therapist and team
• Provision of a rapid timely response
• Expertise in working across health and social care boundaries
• Holistic assessment of the person’s routines, mobility, home environment, use of adaptive equipment, cognition and care needs
• Multidisciplinary teamwork.
Reducing time in hospital

Recommendation 3: To achieve optimum patient flow and fast-paced assessments, commissioners must include occupational therapy in funding for out of hours services.

The Health Minister, Michelle O’Neill said:

“The root causes of the problem... are representative of the wider challenges to the provision of world-class health and social care – increasing demand; financial constraints; and a slowness to bring about radical change and reform... Therefore, we need new ways of working in health and social care to deliver better health outcomes for our population, reformed organisations that positively promote innovation and enable change to happen quickly and better use of our limited resources to deliver the maximum benefit for patients”

The College agrees with this assessment and to ensure that all opportunities are exploited to improve monetary value, set about gathering evidence where services provided care at times when patients needed it.

Out of hours care

It has been demonstrated that occupational therapy is most effective within acute and emergency care when the therapists are an integral part of the team. When occupational therapists are involved in reviewing admissions, they are able to identify people who require an assessment and offer a timely intervention. The benefits of this can be maximised through extended hours and seven-day working.

Emergency Department, Clinical Decision Unit and Acute Medical Unit within Craigavon Area Hospital, Southern Health and Social Care Trust.

Occupational Therapy is offered in the Emergency Department (ED), the Clinical Decision Unit (CDU) and the Acute Medical Unit (AMU) across seven days. The service responds to referrals within one hour and assesses function, activities of daily living, cognition and psychological wellbeing in relation to occupation, roles and routines.

Goals and outcomes are agreed with the patient and family, and the team liaises with other disciplines and agencies involved in the person’s ongoing care. Equipment and assistive devices to help improve independence and reduce caregiver dependency are prescribed and arrangements for follow-up are made.

On average the service sees 100 people per month, with typically 70% discharged without needing admission to base wards in hospital.

- 20% are discharged home with no follow-up required
- 30% are discharged on the same day with reablement support
- 20% are discharged home with intervention and equipment follow-up.

A further 30% of patients are discharged within 2/3 days through Intermediate Care Services.

This has led to an average saving of £129,792 per month. This figure is based on their ability to assess and ensure patients can be discharged (rather than admitted) with adequate support, assistance and advice to meet their individual health care needs.

Seven-day working can facilitate smooth patient flow by ensuring staff are available to offer interventions when patient need arises, rather than waiting until Monday morning. The College has also seen a positive impact when therapists are considered within funding designed to ease pressure points or episodes of intense demand.

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Ulster Hospital, Belfast – Access to occupational therapy in unscheduled care.
The Occupational Therapy Team at the Ulster Hospital, Belfast provide a seven-day service (including public holidays) to the Emergency Department, Observation Ward and Ambulatory Care. The focus is on preventing unnecessary and/or inappropriate hospital admissions. They provide timely assessment and intervention to facilitate safe and effective patient discharge including collaborating with community and hospital outreach services in preparation for resettlement. As a result of this initiative, 41% of patients, who were referred to occupational therapy over a five month period, were able to be discharged directly from A&E, thus avoiding a hospital admission.

What makes for a good service? Key factors for urgent care services:
• Out of hours funding for occupational therapy provision
• Service available to match patient need
• Full assessments considering pre-mobility, transfers, cognition and falls risk, in relation to occupational performance
• Liaison with carers
• Close liaison with and speedy mobilisation of social care and community services.

Optimising patient care
Recommendation 4: All multidisciplinary admission and discharge teams across the hospital environment must include occupational therapists, with therapy-led discharge planning for people with complex health care needs.

To have an effective multidisciplinary, seven-day approach, the balance of disciplines must reflect the needs of the population it serves. It is vital to match the skills of the profession with the need the service aims to address. Preparing people to manage their condition and health and social care needs at home requires expertise on goal-setting, managing daily living and adapting and adjusting to overcome barriers.

In comparison to the role of doctors and nurses, the value of allied health professions (AHPs) is less well understood and they are often seen as an ‘add on’. It is therefore imperative to commission expertise to address need, which is proven to improve patient experience and offer the right range of interventions that can be offered to help bring people back to health.

David Oliver, Visiting Fellow from The King’s Fund, has said: “AHPs are critical in getting patients back to their own home quickly from the front door of the hospital and ensuring good inpatient rehabilitation and discharge planning.”

The role of occupational therapists in delivering person-centred care also applies to mental health hospital services. As the following service example demonstrates, reviewing the multidisciplinary mix within teams, the levels of experience and responsibilities required can improve clinical outcomes for patients.

Mental Health Crisis Service Western Trust
The Mental Health Crisis Service in the Western Trust has two acute admission wards; a Home Treatment Team and an acute day hospital. There are three occupational therapists based in the acute day hospital as part of a multidisciplinary team who provide interventions for people who are stepped up from the Home Treatment Team, or for inpatients stepped down from the hospital. The acute day hospital provides services so that people can be supported in the community, thus avoiding admission to hospital or the need to spend less time there when admitted.

The occupational therapists provide motivational and educational groups aimed at promoting daily structure and routine, engaging people in meaningful activity and promoting recovery. Before being discharged, patients are actively encouraged by the occupational therapists to engage with community resources. This signposting, together with partnership working between statutory and community services, enables people on discharge to access the support they need to stay well.

Of those discharged:
• 40% accessed counselling services;
• Over 30% went to both day centres and recreational services;
• Over 20% to both addictions and training/education and 10% were referred to self-harm services.

The occupational therapy support has led to an overall patient reported outcome of 100% feeling fully supported to explore options appropriate to their needs.

The vital role of occupational therapy, commissioned to meet a clearly defined need, is exemplified by specialist occupational therapy teams that work across hospitals and community settings. This integration provides a joined-up approach that avoids duplication, ensures greater consistency of care which helps patients get to know and navigate the support they and their family need.

“My firmly held view is we are missing a trick by not freeing up and empowering occupational therapists to take a lead practitioner role in the management of my patients with multiple co-morbidities.”

Dr George O’Neill, GP, Springfield Road Surgery, Belfast and Former Belfast LCG Chair

Therapy-led services are a more effective model than traditional services when reablement or rehabilitation has been identified as the main need. In reviewing the effectiveness of patient goal-setting, Plant et al17 conclude that staff’s knowledge, experience, skill, and engagement with goal-setting can be either a barrier or a facilitator. Occupational therapists focus on what a person needs and wants to be able to do to return to their community and considers the environment and how it supports or hinders the person in their daily occupations. This understanding and expertise helps patients to set goals that enable them to return to living their lives.

Reablement led by occupational therapy in Northern Ireland has been very successful. For the year 2015/16:
• 5,031 people started reablement
• 84.4% were discharged within six weeks
• 40.9% of those reabled were discharged without the need of a further care package18.

In other parts of the UK occupational therapists are leading in-patient services. For example, Scotland now has two consultant occupational therapists in roles traditionally associated with medical consultants. They are demonstrating that a shift in ethos on the wards is saving money and improving outcomes for people.

Occupational therapy-led stroke unit

NHS Grampian has two stroke units, one led by a consultant occupational therapist and the other follows a medical model. In 2014 the median length of stay in the consultant occupational therapist-led unit was 28 days and 55 in the other. In 2015 a similar result: 27 and 59 days. The consultant occupational therapist is now responsible for some of the beds on the second unit in order to support a similar person-centred rehabilitation process, which has an impact on the effectiveness and efficiency of services. Patients have reported increased satisfaction and improved ability to engage in their chosen occupations, including ability to return to roles at home, at work and socially.

What makes for a good service? Key factors for rehabilitation and reablement services:
• Occupational therapists leading teams
• Expertise to support patients in setting goals that enable them to return to living more independent lives
• Innovations from occupational therapists to bring new ways of working through their core dual training and holistic approach
• Skilled staff who are trained to work across hospitals and community settings
• A focus on patient experience and outcomes related to quality of life.

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17 Plant SE, Tyson SF, Kirk S, Parsons J (2016) What are the barriers and facilitators to goal-setting during rehabilitation for stroke and other acquired brain injuries? A systematic review and meta-synthesis. Clinical Rehabilitation 30(9), 921-30. Available at: http://cre.sagepub.com/content/30/9/921.full
The negative impact of being in hospital, when it is no longer necessary, is well documented and it is well known that occupational deprivation exacerbates long-term dependence.

The College has identified that the issues occurring in discharge are two-fold, timely in-hospital assessment plus associated discharge planning and secondly a robust social care system to take on the care requirements of those in need.

The discharge pathway

Recommendation 5: To ensure timely and successful discharge, commissioners and service providers must support the development of therapy-led services.

Occupational therapy plays a critical part in the discharge of patients from hospital at multiple patient contact points. Results from surveying members of the College indicate that 98% of occupational therapists believe they can play a significant role in the effective discharge of patients. Many patients have complex co-morbidities and social situations which need resolutions within a rapid time frame so a successful discharge requires liaison with a vast range of personnel and organisations. Every day, occupational therapists work with families and friends, community rehabilitation teams and nursing teams, homecare and residential care providers, third party organisations and adult social care and housing services to help secure the best support for their patients’ needs.

With such in-depth knowledge and experience of discharge, occupational therapists have proven to be innovative in reconfiguring the discharge pathway when given the opportunity to do so.

College of Occupational Therapists – Reducing the pressure on hospitals: a report on the value of occupational therapy in Northern Ireland
Muckamore Abbey Hospital, Belfast Health and Social Care Trust
Resettlement from long stay hospital wards

A service audit showed that 98% of people with learning disabilities discharged from a long stay hospital remained in the community 19 months after occupational therapy involvement in the resettlement process. This reduced the need for costly hospital re-admissions or delayed discharges which often impacts negatively on mental health for service users. The results have shown that the occupational therapy service has had a positive and significant impact not only on service users but also on staff within Muckamore Abbey Hospital.

The unique role of occupational therapy included standardised functional assessments; comprehensive and rigorous assessments regarding all aspects of activities of daily living, postural management, wheelchairs and positioning; falls prevention; sensory integration; environmental design and modification for those with challenging behaviour and independent and community living skills.

Following audit, 100% of service users reported that the occupational therapy service had prepared them for resettlement.

“This is a first class service. Sometimes in the world of resettlement (community integration) there are unresolved issues and uncertainties. They [the occupational therapists] have sought to cut through this and have acted to clarify and help and succeeded.”

Staff quote, Muckamore Abbey Hospital.

Occupational therapists bring a unique approach to the understanding of patients’ lives outside of the hospital environment. Older people, in particular, do not perform well in a hospital environment, leading to a risk-adverse approach to discharge and delays whilst complex care packages are put in place or a residential place can be found. An assessment in the person’s home often reveals a more realistic picture of their abilities, as it can show how a person can carry out daily activities (occupations) when in a familiar environment especially when assessing a person with dementia or multiple co-morbidities.

What makes for a good service? Key factors for discharge planning services:

• Daily ward meetings to review progress
• Assessment in the person’s home for older people with complex needs
• Risk assessment to develop risk enablement plans
• A robust social care system to take on care requirements of those in need
• Skilled staff who are trained to work across hospital and community settings.

Person-centred support

Recommendation 6: Occupational therapy-led reablement services should expand to include all adults and provide a seven-day programme of care.

If the Northern Ireland government wishes to move to more community-based, person-centred, integrated and prudent services, as Transforming your care\textsuperscript{19} intends, then a more flexible workforce, able to work intelligently across the sector, is needed. Looking at the workforce in this light is an opportunity to think more creatively about how Northern Ireland can improve workforce planning and education commissioning, inter-professional learning and career development in a more innovative way. Occupational therapists have the skills to deliver

\textsuperscript{19} Health and Social Care (2011) Transforming Your Care: A Review of Health and Social Care in Northern Ireland. Northern Ireland Government. Available at: https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care

College of Occupational Therapists – Reducing the pressure on hospitals: a report on the value of occupational therapy in Northern Ireland
on important principles, such as prevention, early intervention, reablement, resettlement, rehabilitation, risk assessments, preventing hospital admission and facilitating safe discharge from hospital.

There has been a significant increase in the number of people needing rehabilitation, community occupational therapy and reablement at primary care level. As a result of the speedy discharge rate from hospital to home, delays are now experienced when occupational therapy services which support transition home are not adequately resourced. When adequately resourced, reablement led by occupational therapy has been very successful. There is further scope for extension in referral age to all adults in need, as well as reviewing existing care packages.

**Occupational therapy-led reablement in Northern Ireland**

The Reablement Project Board completed a Retrospective Longitudinal Audit\(^\text{20}\) in 2014 to determine how long service users benefited from a reablement episode if a person was ‘successfully reabled how long the benefit lasts’.

For the purposes of this audit, the definition for ‘successfully reabled’ was that one of the following criteria must apply:

- The service user has no need to commence a domiciliary care package following discharge from reablement
- The service user has historically received a domiciliary care package, has been referred to reablement and following a reablement intervention the domiciliary care package is reduced on discharge. (i.e. less hours)
- The service user has historically received a domiciliary care package, has been referred to reablement and following a reablement intervention does not require any additional hours on discharge. (i.e. stayed the same).

Each Trust provided a random sample of approximately 50 people aged 65 and over who had been ‘successfully reabled’. The audit findings showed that 77% (192 people) remained ‘successfully reabled’ up to 21 months after being discharged from reablement services.

This was calculated at 82,199 days which equates to net domiciliary care costs avoided of £1.2m.

A small number of the total cohort, 36 service users (15% ) were re-referred for a social care package after a period of time but the length of benefit to these services users equated to 5,239 days which compares to net domiciliary care costs avoided of £32,000.

The report concluded that reablement should be rolled out to all adult services and that domiciliary services should adopt a reablement ethos.

Occupational therapists working in intermediate care and reablement teams can help ensure smooth transition into the community. This can minimise bed days lost to patients who are medically fit and reduce the chance of readmission by maximising a person’s independence.

**Occupational therapy in the community rehabilitation team**

A gentleman in his late 70’s was discharged from hospital post-surgery without support or community follow-up intervention. On discharge home, he fell and was readmitted with a neck of femur fracture. Following this discharge he was placed in a nursing home facility with a view to permanent placement, as medical teams believed that he would be unable to return to his premorbid situation.

Following intervention from the occupational therapist in the community rehabilitation team which included goal setting for occupations (such as activities of daily living and strategies to restore confidence as well as an environmental home assessment) this gentleman was able to return home in three weeks. He was initially discharged with a package of care to support physical and functional activities of daily living which was later reduced and eventually removed as he regained full functional independence and felt able to regain social interactions and return to premorbid situations.

Occupational therapy intervention assisted this gentleman to return home which avoided the necessity of a residential placement or a long term package of care. He is ‘totally delighted to be home’.

Reablement aims to help people accommodate illness or disability by learning or re-learning the skills necessary for daily living. Occupational therapists work within reablement teams to ensure a ‘promoting independence’ ethos and to utilise a person’s strengths in assessment and goal setting to help them achieve personalised outcomes.

“At the start of getting the reablement service, I was a bit apprehensive as I wasn’t able to do anything for myself. I wasn’t able to wash and dress myself without help, I couldn’t make food and the steps throughout the house made it very difficult to manage. I was upstairs in the bedroom all the time. The Reablement occupational therapist saw me first and we discussed what needed to be done to help me get back to doing things for myself.”

“It is great that Reablement is out there to help people get back to doing everyday things for themselves again and not be dependent on someone else to do it for you.”

Service user comments

Repeatedly, occupational therapy shows that when health care systems are better integrated with community services, as in Northern Ireland, financial savings are made in the system. Integration also better mirrors the patient’s own experience; their journey back to health does not end once they put the key in their front door.

The College urges commissioners and providers to put occupational therapists at the front-line of reablement and community support programmes. They should provide occupational therapists with the time, capacity and skill mix to design, implement, and evaluate occupationally-focused programmes that span primary, secondary and community care.

What makes for a good service? Key factors for transition services:

• Occupational therapists at the front-line of intermediate care, reablement and community support programmes
• Utilisation of a person’s strengths in assessment and goal-setting to help them achieve personalised outcomes
• Reduction of unnecessary care packages by improving moving and handling with equipment
• Provision of time, capacity and skill mix to design, implement, and evaluate occupation-focused programmes.

The cost of undervaluing occupational therapy

In the 2016 briefing paper Transforming health and social care in Northern Ireland – services and governance, Dr Janice Thompson highlighted that the government is striving to transform health and social care services in the context of constrained resources and increased demand but concluded that more was needed to make this happen. This included the drive to build on Northern Ireland’s already integrated health and social care systems with enhanced integration on the ground.

Dr Thompson states:

‘…the Integrated Care Models of TYC, are not enough on their own to change day-to-day clinical practice. It also requires processes and resources to help local managers and health professionals to change practice on the ground’.

Occupational therapists can be instrumental in realising this vision.

If health and social care is to evolve from an illness-based, provider-led system towards one that is patient-led, preventative in focus and offers care closer to home, then a reshaping of the workforce is required. Occupational therapy is an under-used and under-recognised existing resource that is trained in and focused on enabling people to live at home and to live well regardless of health or social circumstances.
The College urges commissioners and providers to put occupational therapists at the front-line of reablement and community support programmes.

If commissioners and providers fully utilise occupational therapy staff, they have an opportunity to make the most of a profession that:

- Embraces and can help to achieve new models of care
- Is trained to work across boundaries, physical and mental health and health and social care
- Can support the adoption of a person centred ethos
- Can embed self-management principles across services.

In conclusion...

Occupational therapists are an essential component of an integrated systems approach effectively improving: flow, future workforce models, seven-day working and the joined-up approach needed in Northern Ireland.

With ever constrained resources the correct infrastructure, services and workforce model must be put in place on a sustainable basis to turn the tide on the ever increasing strain on emergency care. There are growing opportunities to develop an integrated approach right through from prevention and early intervention to urgent and emergency care, involving hospitals, community, primary care and ambulance services through joint service planning across different agencies.

Occupational therapists work across these sectors. This transformation offers an opportunity to ensure that the right workforce is in place with the right skills to meet needs.

The HSC will fail to deliver what it needs to, by way of improving lives, if the role and value of occupational therapy is not understood and the skills of this workforce are not maximised and mobilised to where they can be most effective. Occupational therapists are that vital cog between people and better lives.

https://portal.rcem.ac.uk/LIVE/docs/Policy/CEM8011%20Recommendations%20for%20Unscheduled%20and%20Emergency%20Care%20%20%20%20%20%20Northern%20Ireland.pdf
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