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Service need

We developed this project initially because post pandemic, we have a long waiting list and at the same time, a higher need for the people in the community who are most vulnerable such as residents in care homes. We wanted to find a way that we can provide a better service for them but at the same time, staff were also tired, exhausted during the pandemic. How could we provide better service, and at the same time, sustain the energy of our workforce so that we can actually make sure that our service is sustainable?

I approached one of my colleagues, a clinical lead pharmacist, and asked him the same question. As a speech and language therapist, one of our expertise is to provide assessment and intervention for people who have swallowing difficulties. Our residents in care homes, are frail, they have difficulties eating and drinking because of the weakness of their mouth, the muscles of their lips and tongue. At the same time, our colleagues in pharmacy also had difficulties making sure medications were actually taken and maintained, particularly for those residents who had swallowing difficulties, who can't swallow their medications on time because of the difficulties that they have. We started thinking; as part of this community integrated team, what if we could develop a new way of working? Wherein we go in to provide a service as a team, a joint session together.

We then challenged ourselves, are we the only professions that can actually provide this? One of the partners that we work closely with is dietetics. I approached the dietetics department and surprisingly, they had the same problem. So we said, well, if we are having the same

problems, we also have the shared risk and by developing a solution together, perhaps we could eliminate all the long waiting lists that we have, improve services by improving communication with each other, and provide care as a joint team, to improve the quality of the service we provide.

Development of the service

So we are now an integrated team and so lucky that we are housed under the Bridgend integrated model. We set out to set up a pathway of care, wherein there's only one point of access for referral for the three professionals. So instead of three referrals, patients just need to use one referral. Instead of waiting lists for three professions, there is one and they don't even need to wait that long because of the efficiency of care that we've provided. At the same time, at the end, instead of them receiving three disjointed reports, it's just one report with all the integrated recommendations provided by all three of us in one single session One session for all of us.

We approached partners in the community. We had four care home partners for our pilot. It was co-produced and co-designed not only by the three professions, but also with those community partners’ contributions from the start. How to develop the referral form, how to actually communicate and engage with clients, how to set up the service and how to communicate the end document. All the pathways are co-designed and with experience we found that it's hard to develop a new service, so how much more develop difficult would it be with three different professions involved? So we went to the Bevan Commission for advice.

The Bevan Commission was very supportive, and we become a Bevan Exemplar. We tapped into TEC Cymru to help us as well, because the only way for us to move this forward was for us to use digital technology. Anyone can access this service. It's an open referral. Training for all the care homes is available because we rolled it out across all care homes in Bridgend after the pilot so all of them can refer with just one referral form and access all three disciplines.

We triage as a multidisciplinary team as well so we identify the most vulnerable and we see to them immediately. After assessment, we then book the intervention session. We provide a service now that means instead of us going to them, we train our community partners, the staff in care homes, staff know the residents well and the residents trust them, they have this relationship. So instead of another person going there to tell them I will be touching their throat for example, they interact with the people that they trust who have a real picture of how they behave when they're eating and drinking, how they behave when they take their medications so we provide the assessment remotely.

All clinicians are in their clinics, in their hospitals. So it enables us to be more efficient with our caseload. At the same time, the residents are more relaxed. They're in the care home. They don't need to travel because most of the time when they travel to their appointment, by the time they arrive at the hospital setting, they are tired so we can't really get a good picture when we do an assessment. But in the care homes with the people that they trust, and us remote assessing means we welcome family members as well. They can be there in the care homes or if away, they can attend virtually as well. So as much as possible, it's all inclusive. It's seamless care. Not just seamless care for health professionals, but also inclusive for families, inclusive of people in the communities and respectful for residents so that they'll be relaxed and comfortable. And when we actually do the assessment, we make sure that whatever questions that the family has, that the carers have, these would be addressed too during that session. Because all three of us are there, we're able to address whatever concerns that they have, if there's any medication issues that they have, swallowing issues or nutrition, hydration issues that they have. It's all addressed in one single appointment. And at the end, we just make sure that all information is given to them. We try our best to send the information as quickly as possible. And again, we do this digitally.

Role of education and training

All of this was possible because we also have a really robust training system. We train care staff with information and to know how to do the assessment properly, we also do like hands-on training with them. During the initial phases, somebody from our team would be there in the care homes to provide support for them. Somebody from TEC Cymru would be there as well to do an induction for the technology that we're using. So to make sure that everyone will be supported for this new way of working. And I guess at the end, we just want to make sure too that everyone is safe in their practice. So we make sure that the policies are in place, service agreements are up to date as well, so that it's not just a new way of working, but also making sure that everyone is practicing at their standards and everyone's comfortable and safe in their practice.

Benefits of the service

We were very ambitious when we set up this project. We were thinking, might as well use the "Quintuple International Health Improvement Goals". Newly published by WHO during that time. We were thinking that we might as well target these five. So one is better experience for our residents. Second is better clinical outcomes. Third is costings, of course. And the two new ones are, fourth one would be better quality of service through sustained workforce. And the fifth one is equitable care for all.

And we are really concerned about the fifth one because these are elderly population, high risk and very vulnerable. And we're using digital health. So we're trying our best to actually target as much of this five as possible. And we're happy to report that we have. During our pilot, we are able to show that we've improved the experience of our residents and the care

home partners that we have. So we reduced the waiting list to 70 percent. So we are being seen faster. And not only that, but they’re being also seen by all three professionals in seamless care, in integrated way. And they don't need to travel as much and disrupt their routine in life. So that's one. And second is that we really focused on the clinical outcomes on their quality of life. We want to make sure that our input is not only medical, but really want to make sure that our input is more impactful in the day to day on how these residents are actually living. So we focused on three key measures for quality of life. That's activity, participation and well-being.

And most of their residents are, as I said, very frail and their quality of life as expected usually goes down over time. However, when we compared before and after, we actually see not only maintenance of quality of life, but actually an increase of quality of life after the intervention that we have. And the third one, cost. Initially, we were thinking that this might not actually benefit when it comes to cost, but we actually were able to show that because one, we ‘re using remote services, we're able to cut down on travel costs and time for clinicians as well because we’re able to see more people. Two, our capacity has increased in the community because of the streamline that we have. So at the end of the year, we're able to see 100 more community patients because of the streamline service. And third is that because we're able to see them promptly, we're able to put things in place so that if they do exacerbate, then we have a plan, anticipatory care plan for them, for everyone, the family, the care home staff. To know what they're going to do if these things happen, then we're able to prevent unnecessary hospital admission that our residents don’t really want to be in hospital. But we're able to put that in place early.

And so our outcome showed that we're able to save 360 days of hospital admission for our care home residents. And these are from our pilots alone, only from four care home partners. In the fourth one would be our workforce. We are very concerned and very aware that the workforce in health and social care has gone down significantly during the pandemic because of the stresses that's added to these to these roles. And what we've done is that we've done, we’ve collated pre and post questionnaires on how they feel and their level of confidence before and after the pilot. And at the same time, we've done some interviews as well with our key stakeholders. And what we've actually seen is that they've improved their confidence on how to manage high risk assessments like these remotely, how to manage their residents. But also, I remember one of the interviews that we had was that she, one of the nurses said that she’s proud to be a nurse and she is proud to be it elevated her humanity. Because she's able to connect more with her residents that that was really impactful for us. And also, when it comes to workforce with working with my colleagues. Again, we're so lucky to be in an integrated service here in Bridgend and we're in, This is a way for us to fully understand and live how integrated working can really benefit our residents.

Lessons learned

I needed to shed some of my professional boundaries so that I can work alongside my dietetics and pharmacy colleagues. And by doing that, I believe that we started a way to break the silos in our own individual practice. And I learned so much about dietetics and how they work with pharmacy, and I felt really supported with my colleagues. And these are high risk patients as well needing high, you know, really intensive need to meet their intensive need and complex needs. But because I have my colleagues, I feel really confident that my recommendations are sound that I am providing the best care that I have. So I feel really I feel accomplished as speech and language therapist working alongside my colleagues. And lastly, the fifth one that we have in the quintuple aims is health equity. So again, we were really concerned of using digital health in an elderly population in I guess nursing home institution. But what we found when we actually collected the data is that 80% of all the referrals that came to us was able to complete the whole pathway from start to end. Using the digital pathway now I agree digital is not for everyone. It’s one of the tools that we can use to provide better service and so the 20% I acknowledge that we need face to face, and we still provide face to face service for them. But 80% is actually high to showcase that using digital technology is not impossible for elderly population for institutions. It’s really just having again really good partners TEC Cymru was brilliant with helping us to set it all up and providing I guess a different way of accepting that technology is nothing scary. But it can actually help us so that we can provide better service and at the same time it will help us to be safer in our practice as well. So those are our five quintuple aims.

One thing that I learned from doing this project is a change in my leadership style. In the past, I would always lead in front, pull people with me and then I just charge forward. But with this project I realize that leadership is not only by one person. Leadership is shared leadership in an integrated care hospital admission, that it's a prudent way of working so that we won't access additional services like ambulance, and we didn’t really need additional services. We maximize the current service that we have from dietetics, speech and language therapy and pharmacy. And at the same time, we're able to showcase that digital technology is able to show health equity even for the most vulnerable, our elderly in the community. And this is made possible only because it's a way for us to use integrated model in the community. We’re in its seamless way of providing services. And at the same time, we elevate the quality of life of our residents in care homes.