Argyll & Bute Occupational Therapy Review – 'The Occupational Therapy contribution to effective integrated pathways and services'

1. Background - Key themes & Objectives of the review

The A&B OT review has been initiated by local stakeholders to ensure the most effective use of Occupational therapy resources, in the evolving service models and pathways being developed to deliver the new integrated arrangements for Health, Social care and Housing partners. Facilitation support has been provided by Improvement Hub colleagues from the 'Place, Home, and Housing' workstream, Alison Docherty and Jill Pritchard.

This review has presented an opportunity for stakeholders to refocus on the contribution of OT resources, and to redefine the optimum Core role of occupational therapy within the integrated service pathways, to ensure the most effective Outcomes for service users. This is fundamentally about delivering broader service improvement within the wider care group pathways, and therefore this review has also focused on how best the OT role compliments and supports the contribution of all relevant professions and social care staff at key stages of service intervention including hospital discharge and crucially, the avoidance of admission.

It has also been important to acknowledge other recent service review work to ensure a cohesive approach to potential improvement solution e.g. review of district nursing, implementation of the Burrtzorg model, future review of community services and the integration of health and social work in Argyll & Bute.

Objectives of the Review:

- To clarify the Core role and maximise the effective contribution of Occupational Therapy in the emerging Integration pathways and service arrangements;
- To identify improvements to the interface with other professions and support staff,
- To clarify the roles of non-OT staff in the provision of services and interventions at critical stages in the pathways.

2. Method of Review

It was agreed that this would be short service review over a maximum of 4 sessions. The first review session brought together Occupational Therapy staff, team leads and AHP Lead to review current roles and identify issues and blockages in the pathways impacting on service provision. The second session clarified the essential components of the Core role for OT, and helped consider the ways in which the roles of other non-OT staff could contribute to overall service and pathway improvements.

The third session involved the same OT group and also included Physiotherapy representative and Lead Nurse in a review of example Service user stories from across Argyll and Bute service settings. The stories of these service users have been used to illustrate and understand current issues within the wider pathways and how these impact on the individuals themselves, in order to assist in

identifying potential improvements. From that session, key themes/issues/and opportunities for improvement, have been identified, as illustrated in **Appendix 1**

3. Outcomes from the Review

Overall the Review has highlighted a wide range of issues some of which relate directly to the need to improve the use of Occupational Therapy resource, but also include issues which are more broadly related to the interface with other services, and roles and responsibilities of other staff and professions. The Service User stories in particular, highlighted common issues with too many professions/staff involved in delivering service inputs, and a lack of clarity around co-ordination and lead responsibility for individual cases. Although individual service input was often effective in itself, the lack of co-ordination between other relevant services, meant that this often resulted in a longer, protracted, and confusing process for the service user and their family, and frustration for staff trying to resolve these issues. The sections below draw out the key themes from the review process, and the recommended Actions to deliver effective solutions:

3.1 Occupational Therapy Core Roles

The Review has identified key categories of roles specific to Occupational Therapy. The aim of this process was to clarify how best, the Occupational Therapy resource, should be used to ensure the delivery of effective Outcomes for service users accessing those services in the pathways. **Appendix 2** details the proposed redefining of the Core roles for OT staff, and also illustrates the sharing of roles with other staff/professions. The partnership is asked to prioritise the use of occupational therapy skills in providing those activities in a proactive and preventative way by ensuring the integrated and joint working outlined below.

- **Holistic Assessment of need (occupation and activity)** – This role encompasses a range of assessment interventions related to Occupation and activities of daily living which impact on the functional, cognitive and psychological performance of individuals. These are core functions which need to be supported in order to help the avoidance of admission to hospital, discharge planning, and ensuring we keep people living at home, healthy and independent as possible.

- **Rehabilitation and Reablement OT Interventions and solutions -**
  Therapeutic interventions are focused around delivering Rehabilitation and Reablement, and promoting prevention and self-management. The specific skills required in functional assessment and goal planning and training for other staff to build up enablement skills is a fundamental part of maximising independence in our community. It is important that it is recognised that although this is a key OT role, it is essential that other relevant professions are involved as part of broader Rehab and Reablement interventions to ensure the most effective outcomes for people in our communities.

- **Equipment and Housing based OT interventions and solutions -**
  Additional roles to enhance the enablement approach are related to the assessment for equipment, adaptations, and housing solutions. OT input should be focused around complex

Equipment and Adaptation needs, with more generic needs met by other relevant staff in the pathways without the need for an unnecessary referral to OT.

- **Prevention and self-management** –
  The review identified that, at present, there is little opportunity to intervene early enough in the pathways to proactively support prevention and self-management strategies. The development of an improved service model which utilised Occupational Therapy staff around a better defined 'Core Role', would help support targeted preventative interventions and would link with a more seamless 'Anticipatory Care planning' approach.

3.2 Interface with other professions and support staff

There were common issues highlighted within the service user's stories which included:

- Multiple staff involved leading to duplication of work and numerous visits.
- Multiple hand-offs of service users during their journey
- Lack of lead professional, delegated responsibility of care co-ordination

In order to address these issues the multi-professional review session identified the following recommendations for improvement:

- Anticipatory care enhanced to reduce the impact of common infections and periods of illnesses in our frail population, and better planning with carers and families as to how to deal with those episodes.
- Use of the virtual ward with an improved link to primary care
- Ensure timing of referrals effective, often late when functional impact significant, requiring urgent intervention
- Review of policy to 'end of life care' particularly around provision of equipment. Move to 'minimal intervention' and simple solutions, and address expectations of care staff and professionals in terms of use of hospital beds.
- Prioritise single point of access with referrals streamlined through robust screening, generic assessments to support seamless provision of service.
- Review of ECCT teams; needs to be configured to use resources most effectively. Review current model to improve arrangements with greater clarity on 'role' and 'purpose'
- Responder service for falls – appropriate use of independent provider or fire service responder and integrated approach for support and follow-up by ECCT for OT/Physio/community nurses/Social workers

3.3 Roles of non-OT staff

In clarifying the Core roles for OT staff, the Review has identified the need to share roles with other staff in the pathways, or for other staff to have full responsibility for certain functions.

- Increased skills ('resilience') required in Home Care staffing group to support people to stay at home without relying heavily on professionals for additional input.

- Designated staff within appropriate settings require to deliver this statutory function on behalf of their own staff group. A current gap is the lack of M&H assessors in Home Care services and social work.
- Assessment for the provision of M&H/transfer equipment for service users - should be a responsibility of any staff likely to be involved in the provision and not just OT staff. Broaden the responsibility for the provision of this equipment to include more nurses, Physio's, social work and home care procurement staff.
- Continue to broaden responsibility for all simple community equipment provision to all relevant professions and support staff, with clarity on roles and responsibilities
- Establish core competencies for qualified and support staff to 'maintain at home'
- Enablement and reablement skills as part of core business within any assessment and care planning.

4. Summary & Recommendations

- Formally implement 'Core Roles' for Occupational therapy with an agreed vision as to the best use of this resource to meet wider integrated service objectives
- Establish Lead professional/care co-ordination role and single point of access with robust triage for single response
- Broaden and establish anticipatory care to support periods of expected ill-health
- Review end of life care, work towards minimal intervention if appropriate
- Review of ECCT team roles and establish strategic leadership
- Ensure teams resourced appropriately and supported in response to falls
- Establish manual handling assessment skills for wider group of health and social care staff and home care providers
- Roll-out core competencies around equipment provision to wider group.

The Strategic Management team is asked to support;

1. Implementation of the recommendations as part of a wider clinical review of community services

2. Review the 'Model of Care' strategy document, evaluate progress against it and produce strategic key priorities for community teams to work towards/evaluate progress against.

2. Ongoing locality support for NMAHP and SW/HCPO group to support local team leads in implementation and progress of local community team action plans.

3. Incorporate accountability of locality community team action plans (that encompass the recommendations) to relevant group (SnrNMAHP, Patient Pathway and/or OMT's)

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Appendix 1

Review Session 3 - Key themes/issues from Service Users stories

Themes/Issues	Opportunities/Solutions
General themes/issues	• **Lots of different professions/staff are involved. We need to be clearer about who takes the lead, who's got overall responsibility, and who is co-ordinating relevant inputs to avoid duplication in roles, and delays in service provision/response.** • **Need to improve 'resilience' in Homecare so they can manage situations better e.g. when a service user gets an infection that affects them short-term, without the need to unnecessarily involve other professions.** • **Need to get better at 'Anticipatory care' in its literal sense e.g. we can anticipate the types of issues certain frail/elderly service users are likely to have; the types of common infections, and the way they will impact. Need to learn from these examples and Plans should be in place so that everyone (the service user/families/formal carers/staff) is clear on what should happen when someone is impacted upon by infection/'goes off their feet'.** • **A 'virtual ward' solution would have been beneficial in some of the Service user examples – need to have clear triggers for when this would be appropriate.**
Improving Service users Outcomes	• **'Mr B' – too many people involved and system too slow to identify deteriorating situation. Need to learn from Mr B's experience, use 'virtual ward' and properly anticipate and plan for likely future episodes of illness.** • **'Mr C '– services need to allow people to die at home with 'minimal intervention'…allowing them to be in their own bed where ever possible, and avoid 'automatic provision' of hospital bed/specialised mattress! Local policy and practice to be reviewed to ensure person centred approach minimising equipment provision to simple solutions, and addressing expectations of formal carers.** • **'Mrs F' – in Mrs F's case, no one was taking on accountability and ownership…..an example of a 'broken system'! Need to have lead professional/care manager to have overall co-ordination and communication with relevant service inputs.**
	• **Need "underpinning culture of Integration"!**

Improving Pathways & processes	• **Need improved access to Core community equipment for urgent needs – the service level, types of equipment, and responsiveness, should be determined by the Partners.** • **Provide an 'Anticipatory Care plan' approach** • **Have lead professionals/care managers for overall co-ordination of service inputs** • **Stream referrals for all needs through single point of access, with robust screening and generic assessment to support the co-ordination and seamless provision of service inputs e.g. do not assume a fall or M&H issue is an OT referral** • **Review policy and practice in the provision of equipment for 'end of life'.**
Improving service models/structural arrangements	• **Single point of access** • **Better/extended use of MDT arrangements** • **Responder service for falls – using Carr Gomm should address inappropriate call outs for OT/Physio** • **Extended Community Care Team – needs to be configured to use resources most effectively. Review current model to improve arrangements with greater clarity on 'role' and 'purpose'**
Improving Roles and Responsibilities	• **M&H Advisor role (for provision of equipment used by Homecare staff) needs to sit with Homecare and roles and responsibilities clarified** • **Homecare – needs role reviewed and training improved (SVQ opportunities) to ensure 'resilience' in managing service users changing needs** • **Assessment for the provision of M&H/transfer equipment for service users - should be a responsibility of any staff likely to be involved in the provision and not just OT staff e.g. Physio, nurses..** • **Broaden responsibility for all community equipment provision to all relevant professions and support staff, with clarity on roles and responsibilities** • **Holistic functional assessment – ability for all relevant professions to carry this out and not just OT e.g. nurse example for 'Mr C'** • **Leadership – this needs to be emphasised in terms of individual care management and overall ownership for the delivery of effective, seamless services.**

Core Occupational therapy Roles and the Roles of other relevant staff

Appendix 2

CORE OT ROLES	ROLES SHARED	ROLES OF OTHERS
1. OT HOLISTIC ASSESSMENT OF NEED (Occupation and activity) – Functional, cognitive, and psychological.		
2. IDENTIFICATION and/or, PROVISION OF **REHABILITATION AND REABLEMENT OT INTERVENTIONS & SOLUTIONS**- to address a range of functional, cognitive and psychological levels of need. Either directly provided by OT or supervising others to deliver appropriate interventions. **3.** PROVISION OF **EQUIPMENT, & HOUSING BASED OT INTERVENTIONS AND SOLUTIONS -** Assessing service users to identify solutions to address ***complex*** needs. Providing a range of Core and specialist equipment, Housing and Adaptations solutions. **4.** PROVISION OF OT INTERVENTIONS AND SOLUTIONS TO SUPPORT **PREVENTION (including crisis intervention) AND SELF-MANAGEMENT** - to address a range of functional, cognitive and psychological levels of need.	  	**REHABILITATION AND REABLEMENT INTERVENTIONS & SOLUTIONS** – to address a range of needs. - Physio's; Care support workers; ward nurses; Social workers in specialist teams e.g. Dementia….; Care Home staff etc…. - Support staff may be delivering interventions under supervision of OT or Physio…Role of all non-OT staff should be clearly defined in terms of the strategic objectives of the service provision. **EQUIPMENT & ADAPTATIONS INTERVENTIONS AND SOLUTIONS** - to address a range of needs. - Physio's; Community nurses, care support workers etc. all able to assess and provide a range of Core community equipment (including hoists, beds, mattresses), non-complex adaptations and Housing solutions. - Care Homes providing their own equipment e.g. standard specialist seating per National Protocol *ROLE OF COMMISSIONERS - **PREVENTION (including crisis intervention) AND SELF-MANAGEMENT** - to address a range of needs - Physio's; Community nurses, care support workers etc. all able to intervene in the service pathways to support prevention and self-management, including the provision of equipment & minor adaptations.
	PREVENTION OF ADMISSION TO HOSPITAL/CARE SETTINGS **FACILITATING DISCHARGE** – MDT approach **CARE PLANNING/LEAD PROF**	
		MOVING & HANDLING ASSESSMENT - to assess the needs of ***staff*** involved in moving & handling service users. - Designated staff to be identified in appropriate settings to deliver this statutory function.
TASKS THAT SUPPORT ALL FUNCTIONS/PROCESSES: Screening/triage ; caseload management ; case recording & use of IT systems ; training		