Occupational Therapy
Alignment of Core Roles within Health and Social Care

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Introduction

The project is set in the context of national drivers and policy including AHP national delivery plan and Public Bodies (Joint Working) (Scotland) Bill where there should be greater alignment of services. As people live longer, healthier lives in the community the focus on building integrated care services is paramount. The aim is to develop a service which is patient centred, efficient and of the highest quality in order to achieve the best outcomes for patients, carers and their families.

Previous work examining the occupational therapy pathway highlighted that patients/service users could have multiple referrals and duplication of occupational therapy assessment and interventions. This project aims to achieve closer alignment of health and social care occupational therapy within localities by identifying competencies and skills required to deliver “core” occupational therapy within a geographical area/locality. The project will also highlight the unique occupation focused approach delivered by therapists which benefit patient outcomes.

It is anticipated that the model will identify core and specialist roles and will develop a model of care that will be delivered by health and social care occupational therapists relevant to specific service settings. Implementing a core role for occupational therapy, across health and social care settings will support the delivery of seamless service provision within the service pathways. This will be based on cooperation and coordination in line with the wider integration agenda.

An occupational therapy service with aligned core roles should deliver a better experience of care and support for individuals and communities where patients experience less inequality and achieve better outcomes.

The project focus is based on patient pathways, outcomes and experience rather than on existing structures.

Review process and key tasks

The scope of the project was agreed at the Joint Management Group, NHS Forth Valley and Falkirk Council. Change Fund resources were also secured from Stirling and Clackmannanshire Council areas.

Although the focus of the work was with Falkirk Council area outcomes will be shared with all partners. Leads were identified, Shiona Hogg from NHS Forth Valley and Carleen Boyle from Falkirk Council. Heather Fraser and Bette Locke contribute to the work.
The group is supported by Alison Docherty from the Joint Improvement Team.

The group links directly to Falkirk Adaptations Working Group where adaptations pathways are being developed.

Occupational Therapists from each of the partners have met for 4 facilitated sessions led by Alison Docherty to review occupational therapy service pathways within health and social care.

Core functions, common activities, knowledge and skills of Occupational therapy staff have been identified.

Service specific training needs have been identified throughout the pathways.

Key principles

An improved outcome for patients/service users would be an appropriate assessment/intervention by an Occupational Therapist with a core level of skill and competency able to deliver the service anywhere in the pathway.

The number of referrals to occupational therapists in the pathway should be reduced avoiding duplication of assessment.

Ensure specialist occupational therapy assessment/intervention is targeted to where it is most effective.

When specialist assessment/provision is required it should be coordinated with existing care to compliment not duplicate provision.

Patient/service users should receive a safe, effective and efficient service from occupational therapists based on the best available evidence.

Patients and service users experience in receiving occupational therapy services should be positive and targeted to meet need and expected outcomes.

Access to occupational therapy should be equitable whether delivered by health or social care.

Core Roles for Occupational Therapy

See appendix 1

The attached template provides an overview of the Core functions, common activities, knowledge and skills of Occupational therapy staff working across all relevant agencies including Social Care, NHS, Education, and Housing services. It recognises the breadth of knowledge and skills that OT staff in different settings will utilise. It also acknowledges the unique occupation-focused role Occupational Therapists bring to a patient/client experience. The core role of an OT is the same, but the types of Interventions, Knowledge and skills required, will be dependent on the service setting within which the OT is working, and the levels of need of the service users being assessed.

Case Study Examples

See Appendix 2

In agreeing a new model for occupational therapy service delivery and number of health and local authority occupational therapy staff brought current patient pathways to a working group. Three case examples were used to illustrate what current happens and then how services could be delivered in an alternative model. The new process model demonstrates the patient would continue to receive core occupational therapy assessment and intervention

without the need for referral on and re assessment. Patients would still require and receive specialist occupational therapy when required.

Applying the Core Role to improve the Service Pathways

Applying the core role model to delivering occupational therapy services will ensure key skills and the unique contribution of occupational therapists are used to achieve improved patient outcomes.

Applying core and specialist occupational therapy roles throughout the pathway will allow services and patient outcomes to be evaluated in the future.

Person-centred coordinated care is key to improving outcomes for individuals who use health or social care services. In applying the core role patients/service users will receive a comprehensive, timely occupational therapy assessment based on their needs.

Information sharing with the service user and among the services will be key to delivering occupational therapy services.

Currently there are services offering parallel services, identifying these current overlapping services will allow frontline staff to be patient centred and efficient, avoiding duplication.

It will be essential for clinicians who work across the 3 local council areas to have one system to work within. Learning and best practice should be adopted over the whole area.

Implementing the Core Roles

In order to implement occupational therapy services with an agreed core role a shared understanding of the core role with appropriate skills and competencies will be required.

Key to implementing an aligned model is a robust structure in which clinical and professional leadership is ensured. Use of Knowledge and Skills framework and Local Authority supervision and review process will be used to implement the model.

With an agreed core role an understanding of the functions and interventions delivered by specialist OT is required. This would ultimately sit within a locality model delivering pathways of care with agreed functions of core and specialist services.

Further work will be required to explore the level of risk identified by therapists within this pathway. Risk identified by therapists in the pathway may be a contributing factor to therapist referring out with functions of the core role.

The OT workforce delivering the service need to feel supported and competent to deliver the core role and when it would be appropriate to seek specialist assessment and intervention.

Recommendations

In order to test the proposed model the project partners would aim to carry out a test of change within a defined area.

The pilot would include occupational therapists within health and local authority following the patient pathway within their defined competencies to fulfil the core occupational therapy role.

In order to progress the pilot the following is required

- Agreement on the principles and elements of the core role.
- Agreement on the competencies within the core role.
- Development of a clear clinical and professional leadership structure for the purposes of the project.
- Development and delivery of training required for all OTs to deliver the core role.
- Agreement of the scope of the pilot eg, geographical area, SWD team area, health team catchment area.
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It is acknowledged that additional resource would be required initially to deliver the pilot. A project lead would be key to implementation. Their role would include:

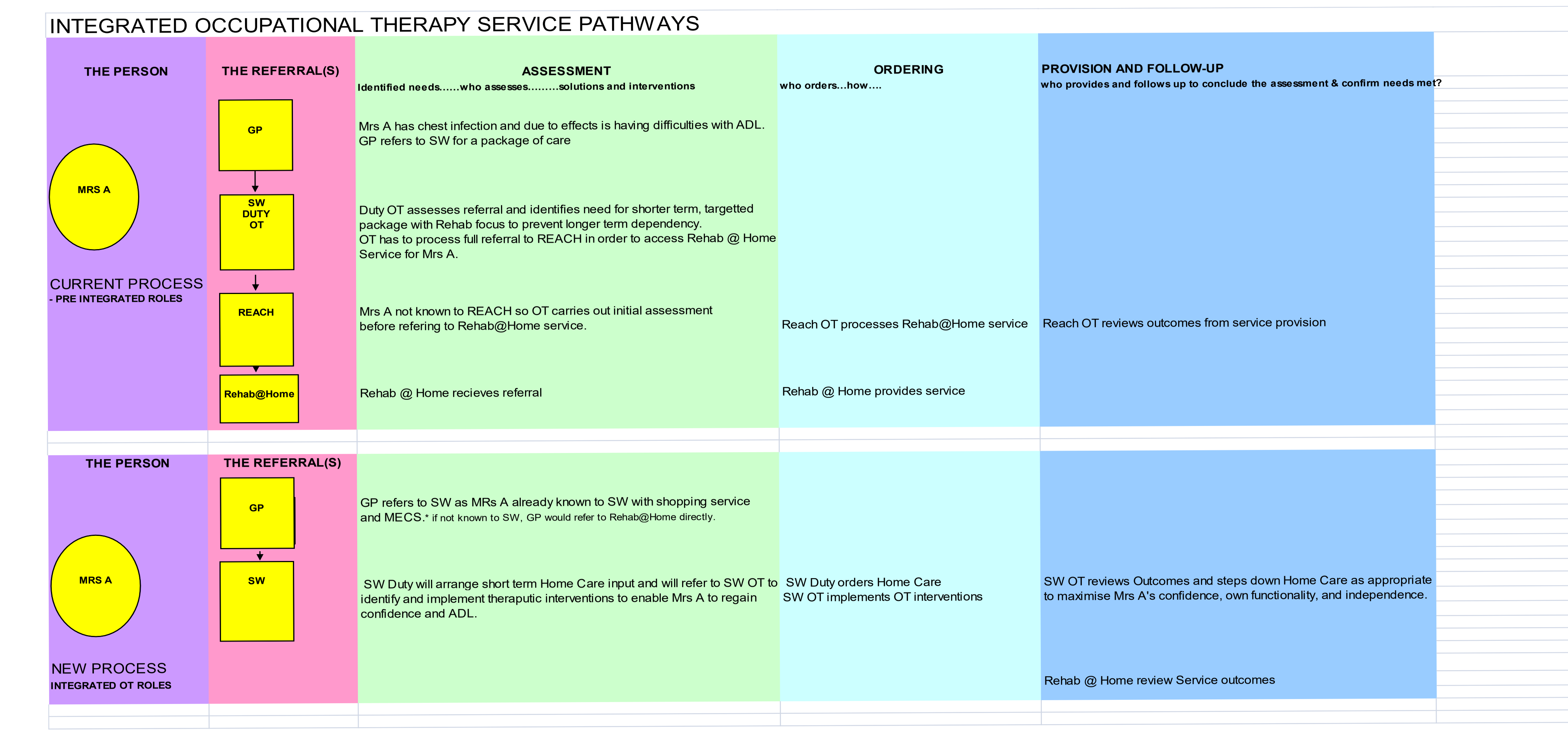
- Co-ordinating additional training required to deliver core role.
- Develop patient pathways within the defined scope of the pilot.
- Ensure appropriate evaluation is carried out to measure effectiveness and impact over time.(outcomes, patient experience, capacity impact)

- Link closely with Falkirk Adaptation Demonstration Site work stream to ensure equity of core roles being developed within that work.
- Scope opportunities to promote wider interdisciplinary way of working with relevant health, local authority and 3rd sector partners.
- Promote timely access to occupational therapy assessment and intervention focusing on the contribution of OT in self management and anticipatory care.
- Link closely with current work being undertaken within Rehab and Acute AHP Care Groups reviewing patient pathways. The aim is to ensure the patient receives their OT/AHP assessment at the most valuable place and time.
- Link closely with work being undertaken by OT/AHP services piloting 7 day working.
- Use learning from this work to inform consideration of a single referral hub.

Appendix 1

STAFF GROUP	Core functions	Interventions	Knowledge & skills	Tools	Governance and support
All OT staff across service settings (all care Groups and ages)	• Holistic Assessment of need – functional; cognitive & psychological; environmental; Social; Risk management • Holistic Provision of OT interventions& solutions • Setting and review of Outcomes • Cognitive/ perception assessment (e.g. staff in Reach & Stroke, Com & inpatient MH OT's)	***Interventions and solutions directly provided by OT staff*** • Occupation & Activity analysis • Reablement • Rehab – cognitive and functional • Assessment & provision of equipment • Assessment & provision of Housing needs and Adaptations ***Other roles*** - Case co-ord/ care management - Identifying and referring on for other services - identifying risk - problem-solving	- Occupation & Activity analysis - Reablement techniques and solutions - Rehabilitation techniques and solutions - knowledge of functional impact of wide range of conditions - range of legislation - Housing regs - Housing options & solutions - Holistic Assessment - MH..dementia - Local resources - Prevention & self-management solutions - Equip &adapt solutions - Technology - Communication/negotiation skills - Outcomes focus & Goal setting - Evidence based practice - Management/leadership - Problem-solving - Educator role	- standardised & non-standardised OT assessment tools - recording tools for baseline assessment - Outcome measures - lorn	- supervision - professional support - competency based training - policies, procedures, Protocols - Pathways - professional development plans - OT forums

Appendix 2



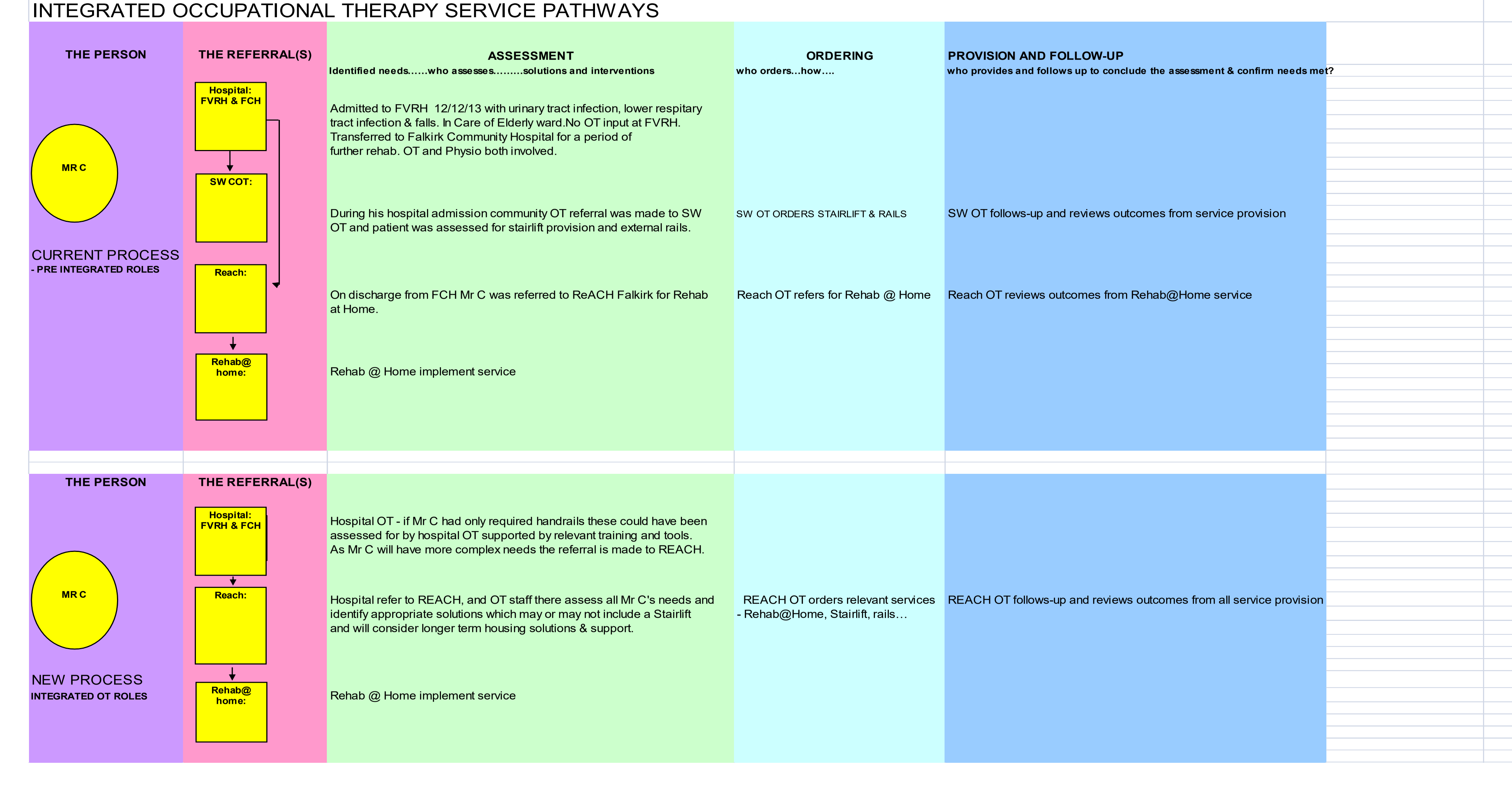
INTEGRATED OCCUPATIONAL THERAPY SERVICE PATHWAYS

THE PERSON	THE REFERRAL(S)	ASSESSMENT Identified needs......who assesses.........solutions and interventions	ORDERING who orders...how....	PROVISION AND FOLLOW-UP who provides and follows up to conclude the assessment & confirm needs met?
MRS A CURRENT PROCESS - PRE INTEGRATED ROLES	GP	Mrs A has chest infection and due to effects is having difficulties with ADL. GP refers to SW for a package of care		
	SW DUTY OT	Duty OT assesses referral and identifies need for shorter term, targetted package with Rehab focus to prevent longer term dependency. OT has to process full referral to REACH in order to access Rehab @ Home Service for Mrs A.		
	REACH	Mrs A not known to REACH so OT carries out initial assessment before refering to Rehab@Home service.	Reach OT processes Rehab@Home service	Reach OT reviews outcomes from service provision
	Rehab@Home	Rehab @ Home recieves referral	Rehab @ Home provides service	
THE PERSON	THE REFERRAL(S)			
MRS A NEW PROCESS INTEGRATED OT ROLES	GP	GP refers to SW as MRs A already known to SW with shopping service and MECS.* if not known to SW, GP would refer to Rehab@Home directly.		
	SW	SW Duty will arrange short term Home Care input and will refer to SW OT to identify and implement theraputic interventions to enable Mrs A to regain confidence and ADL.	SW Duty orders Home Care SW OT implements OT interventions	SW OT reviews Outcomes and steps down Home Care as appropriate to maximise Mrs A's confidence, own functionality, and independence. Rehab @ Home review Service outcomes

INTEGRATED OCCUPATIONAL THERAPY SERVICE PATHWAYS

THE PERSON	THE REFERRAL(S)	ASSESSMENT Identified needs......who assesses.........solutions and interventions	ORDERING who orders...how....	PROVISION AND FOLLOW-UP who provides and follows up to conclude the assessment & confirm needs met?
Miss B CURRENT PROCESS - PRE INTEGRATED ROLES	Hospital: FVRH & FCH	Miss B admitted to Care of Elderly ward. OT assesses needs for discharge and identifies the need for grab rails in the bathroom, raised toilet seat and refers bathing needs to SW OT.	Hopsital OT orders all equipment	Hospital OT follows-up and reviews outcomes from service provision
	SW COT:	Miss B is put on waiting list for assessment for bathing needs	SW OT provides bathlift	SW OT follows-up and reviews outcomes from service provision

THE PERSON	THE REFERRAL(S)			
Miss B NEW PROCESS INTEGRATED OT ROLES	Hospital: FVRH & FCH	Care of Elderly OT assesses needs for discharge and identifies the need for grab rails in the bathroom, raised toilet seat and bathlift.	Hopsital OT orders all equipment	Hospital OT follows-up and reviews outcomes from service provision



INTEGRATED OCCUPATIONAL THERAPY SERVICE PATHWAYS

THE PERSON	THE REFERRAL(S)	ASSESSMENT Identified needs......who assesses.........solutions and interventions	ORDERING who orders...how....	PROVISION AND FOLLOW-UP who provides and follows up to conclude the assessment & confirm needs met?
MR C	Hospital: FVRH & FCH	Admitted to FVRH 12/12/13 with urinary tract infection, lower respitary tract infection & falls. In Care of Elderly ward.No OT input at FVRH. Transferred to Falkirk Community Hospital for a period of further rehab. OT and Physio both involved.		
	SW COT:	During his hospital admission community OT referral was made to SW OT and patient was assessed for stairlift provision and external rails.	SW OT ORDERS STAIRLIFT & RAILS	SW OT follows-up and reviews outcomes from service provision
CURRENT PROCESS - PRE INTEGRATED ROLES	Reach:	On discharge from FCH Mr C was referred to ReACH Falkirk for Rehab at Home.	Reach OT refers for Rehab @ Home	Reach OT reviews outcomes from Rehab@Home service
	Rehab@ home:	Rehab @ Home implement service		

THE PERSON	THE REFERRAL(S)	ASSESSMENT	ORDERING	PROVISION AND FOLLOW-UP
MR C	Hospital: FVRH & FCH	Hospital OT - if Mr C had only required handrails these could have been assessed for by hospital OT supported by relevant training and tools. As Mr C will have more complex needs the referral is made to REACH.		
	Reach:	Hospital refer to REACH, and OT staff there assess all Mr C's needs and identify appropriate solutions which may or may not include a Stairlift and will consider longer term housing solutions & support.	REACH OT orders relevant services - Rehab@Home, Stairlift, rails…	REACH OT follows-up and reviews outcomes from all service provision
NEW PROCESS INTEGRATED OT ROLES	Rehab@ home:	Rehab @ Home implement service		