Royal College of Occupational Therapists

Network Contract Directed Enhanced Services and Community Health - National Service Specifications -consultation response

15th January 2020

This submission is made on behalf of the Royal College of Occupational Therapists (RCOT), the professional body for occupational therapists across the UK. Further information on any aspect of this response can be gained by contacting the RCOT.

Submission

1. **Is there anything else that we should consider for inclusion as a requirement in this service? for example are there approaches that have delivered benefits in your area that you think we should consider for inclusion?**

We would like more mention of the contribution that occupational therapists can and are making to helping PCNs achieve their ambitious change program. Despite many examples, some of which we include here, we are absent from the service specification and need to be specifically named. The growing weight of innovative examples our members are delivering in England makes our omission troubling. Not only are we not included in the Role Reimbursement Scheme, but we are not named in the services here and would have strong roles in three of the six services described; *Enhanced Health in Care Homes, Anticipatory Care and Personalised Care.* Occupational therapists are autonomous practitioners and the profession has a long history of working across traditional boundaries from social care to rehabilitation and mental health. Our members are often the conduits for enabling patients to make transitions from hospital to home and linking primary, secondary and social care to ensure a patient can remain living at home.

Occupational therapists are playing a dynamic role in primary care by enabling patients to self-refer or to be triaged when the primary reason is loss of function and managing daily life. Being seen by the right professional to meet their needs has been demonstrated in various pilots within primary care settings. In one pilot project occupational therapists acting as first contact practitioners reduced the number of GP consultations from 50 to 70% for frail older patients.

Occupational therapists can focus on areas where there is a high demand for example vulnerable patients who do not require secondary services but are at high risk of needing increased levels of support (including possible hospital inpatient admission) in the future if a proactive approach is not taken. Occupational therapists based within GP practices and neighbourhood teams can empower patients to manage their own health and independence, using tools and strategies, and enable them to live independently. Occupational therapy-led assessments and interventions can help solve daily non-medical needs, particularly for frail older patients, those with chronic illness and mental health problems. Interventions include

advice on home modifications, adoption of self-management strategies and skills for long term conditions.

We are currently working with NHS England to produce guidance on occupational therapists as First Contact Practitioners and have many clinicians who currently work as Advanced Clinical Practitioners. For example, Payal Wilson from Manchester University NHS Foundation Trust describes her offer as: cognitive assessment, environmental assessment, moving and handling assessment, falls risk assessment, clinical examination, frailty assessment, diagnostics, functional assessment, research, providing therapeutic equipment, facilitation of learning and medicines management. Our expanding role in medicines means we can indicate patients who may need Structured Medication Review and can have the potential to reduce dosage or medicines required via alternatives such as rehabilitation and engagement in meaningful activities. Current national medicines work alongside development of occupational therapists as First Contact Practitioners will help deliver the services described in this consultation. In addition, we will also be shortly be publishing a report on End of Life Care which considers how occupational therapist support patients to live and die well. We have examples of occupational therapists facilitating patient's choice and control as their physical state declines ensuring the patient can complete the activities they wish in the place of their choosing.

2. Are there any aspects of the service requirement that are confusing or could be better clarified?

The occupational therapy role in *Enhanced Health in Care Homes* could be better clarified particularly for:

- Providing access points to occupational therapy advice for care home teams and reablement providers (step down beds in care homes)
- Training and mentoring role to care home staff to understand how to encourage active participation and personalised care to people with complex needs, often in end of life phase.

The following examples which demonstrate this can be shared:

An Integrated whole home approach to falls prevention - Berkshire Healthcare NHS Foundation Trust's Care home support team. The Integrated Care Homes Service supports 53 care homes, both nursing and residential in the West of Berkshire. An occupational therapist and a physiotherapist have worked with care homes to support falls prevention within the care homes. The work of the team has led to 154 falls champions being trained within care homes, and training has included the use of telecare and falls incident analysis. The team have also worked with ambulance trusts to review the falls policies for these care homes which in some cases were found to state that 999 was required for each fall. This work has enabled care home staff to undertake assessments of patients who have fallen, leading to reductions, where appropriate, in the time residents were on the floor and identification of when a 999 call is required. Outcomes: • A 55%reduction in falls over 6 months in one care home through a change in the way care is delivered to residents who fall regularly. • A 90% reduction in 999 calls by a care home through a change in approach to the management of falls with an

associated 41% reduction in falls. • A 66% reduction in falls in a home that now has falls champions: staff have received falls prevention training and the care home are engaged in the audit process.

Active Residents in Care Home (ARCH), St Georges NHS Foundation Trust, South London Active Residents in Care Homes (ARCH) used a whole systems approach to increase meaningful activity and improve wellbeing of care home residents. It was led by an occupational therapist supported by physiotherapists and therapy assistants and involved three self-selected residential care homes in London. The care homes included cared for older people with or without dementia. The approach was delivered in 5 phases and included 3 months of implementation and 9 months consolidation, by which time the care homes were expected to be able continue ARCH as part of routine care. Residents were assessed to establish individual resident's activity/wellbeing needs in a variety of areas such as mobility, falls risk, nutrition and hydration. Care home staff utilised a traffic light system to highlight the facilitators and barriers to activity. From these, individual priorities were determined for each resident. This process enabled care home staff to see activity as part of routine care and move away from a task orientated approach to care provision. Above two examples taken from: https://www.england.nhs.uk/wp-content/uploads/2019/08/ahp-quick-guide-care-homes.pdf

Airedale NHS Foundation Trust Digital Care Hub in Yorkshire has occupational therapists giving advice to care home staff over skype. The Digital Care Hub was established in 2011 and has become the country's leading provider of telemedicine, delivering a single point of access to expert clinical and social assessment, diagnosis, advice and support through a 24/7 Digital Care Hub, that operates 365 days per year. It is staffed by a highly experienced multidisciplinary team comprising of occupational therapists, nurses, and paramedics, from a variety of backgrounds. The workforce is a multi-skilled mix, able to flex across services and respond to peak demands, ensuring 24/7 resilience across our range of telemedicine services. All calls received by the Hub are answered first time, every time, by a highly trained clinician, ensuring patients receive clinical assessment and advice straight away. This means a smoother pathway and better experience for patients, with the right care in the right place at the right time. http://www.airedaledigitalcare.nhs.uk/about-us/

The Care Home Liaison Team, Tower Hamlets. The care home liaison team within the London Borough of Tower Hamlets, which is attached to the older adult mental health team in the East London Foundation Trust, act as a vital link between care homes and community and inpatient services by supporting the homes to access psychiatry, occupational therapy, physiotherapy, end of life care and other community health services. The service works with the serving GP practices creating a multidisciplinary approach to support management of mental health conditions and falls. The occupational therapists support the homes to provide person-centred care through training, on-site role modelling and working directly with the home staff.

Completed projects include:

- Dementia-specific assessment tool and person-centred activity planning • One-page profiles of residents with staff members • 'Activity bubbles' to enable staff to reduce residents' agitation and improve wellbeing
- Reviewing needs of residents, suggesting ways of breaking activity down and delegating different roles/ steps of activity
- Directly working with residents to address behavioural and psychological symptoms of dementia
- Creating a dementia sensory garden
- Signposting staff to equipment provision, e.g. eating aids, access to ferrules and signage
- Co-ordinating multi-factorial falls assessments, providing basic mobility equipment and signposting on to community services for falls related needs.

Outcomes:

- 191 members of staff trained in Person Centred Dementia Care across 12 care settings since August 2014
- Implementation of a greater range of activities
- Improvement in resident's wellbeing measured through a reduction in agitated behaviours in residents
- Staff report greater confidence and knowledge in person-centred care, partnership working, end of life care, and nutrition and hydration

For more information please see the full report *Living, not Existing: Putting prevention at the heart of care for older people in England*: https://www.rcot.co.uk/promoting-occupational-therapy/occupational-therapy-improving-lives-saving-money

3. What other practical implementation support could CCGs and Integrated Care Systems provide to help support and delivery of the service requirements?

System level partners need to lead workforce discussions about how to optimise the occupational therapy workforce to meet these service ambitions. Local health and social care economies should consider the breadth of occupational therapists' skills and how they could be used more effectively to meet the needs of patients with multimorbidity and/or frailty. Service design should allow occupational therapists to expand their roles in enablement and rehabilitation, giving them the scope to redesign interventions to meet local needs and expectations and to move towards a more preventive and enabling approach. Barriers need to be removed to ensure all occupational therapy services achieve this.
CCGs and Integrated Care Systems can to build on existing best practice, to ensure that occupational therapists:

Engage directly with GPs, either by being based within GP practices or within integrated teams that have direct links with local practices.

Take on leadership roles working with community providers to provide training, coaching and expertise to ensure all carers and staff take a person-centred, enabling approach to work with groups of patients with multimorbidity and/or frailty.

Lead on social prescribing to ensure vulnerable people with complex needs can take advantage of these services. They can challenge traditional boundaries to lead complex case management, seeking opportunities to lead, develop or build local social prescribing offer or contribute to and apply existing research in this area. https://www.rcot.co.uk/news/occupational-therapy-role-social-prescribing

Be innovative in their approach and extend the range of their practice to giving advice, developing resources and working with communities.
Develop mechanisms to support self-assessment of standard equipment and minor adaptations for people with less complex needs.

In short, using the occupational therapy workforce more effectively to enhance the prevention agenda will help to put health and care services onto a more sustainable footing and, more important for any civilised society, enable patents with multimorbidity and/or frailty with to live, rather than just exist. For example, the following *Anticipatory Care* services can be created when there is greater coordination between CCG, ICS and PCN. This example is taken from *Living, not Existing: Putting prevention at the heart of care for older people in England*: https://www.rcot.co.uk/promoting-occupational-therapy/occupational-therapy-improving-lives-saving-money

Community Integrated Care Teams, Nottinghamshire. The service consists of three multidisciplinary teams, one led by a nurse and the other two by an occupational therapist. The service has been designed to reduce the number of people presenting at hospital unnecessarily and to support people identified as high risk to manage their long-term conditions at home. Occupational therapists particularly focus on assessment of home hazards, cognition and ability to manage daily occupations and functions. Following completion of an assessment, the occupational therapist advises on strategies and techniques to enable the person to maintain their routines and to continue to do what is important to them. They may also provide or advise on equipment and adaptations to the environment to support safety and activity in the home. Once the acute need has been addressed self-care advisors may then work with the person on practising techniques and strategies and signposting to community groups and resources. The teams work closely with GP surgeries, accepting direct referrals and attending monthly meetings. This model facilitates timely and effective communication between the services and has reduced the number of unplanned hospital admissions.

4. **To what extent do you think that the proposed approach to phasing the service requirements is manageable in your area?**

These services will only be manageable with enough attention to workforce. For example, occupational therapists are keen to help deliver *Anticipatory Care* that focuses on helping patients stay healthier longer, tackles the wider determinants of health for those with complex

needs and bridge builds to community, social care and the voluntary sector. There is no mention of the occupational role in *Anticipatory Care* and explicit inclusion of our workforce will help deliver plans that are manageable and maximise this opportunity for positive change. More explicit recognition of the need for rehabilitation will make these plans more tangible and manageble. Everybody should have universal access to high quality rehabilitation services in their local community; whether they need support because of a long-term condition, following an injury or to be in the best shape possible to optimize the effectiveness of a medical intervention. There are significant gaps in what rehabilitation support available and this needs more emphasis in this consultation. For example, only 40% people with lung disease and less than half of cardiac patients who would benefit from rehabilitation are offered it. Prioritisation of rehabilitation will drive improvements. Rehabilitation needs to develop to meet modern population needs – through use of new technology, tailored around individal needs rather than condition, provided closer to home, with social prescribing used to make the most from existing sports, leisure and voluntary sector activities. Rehabilitation should be the next major area for change and innovation.

The following examples which demonstrate this can be shared and can all be found at :https://www.rcot.co.uk/promoting-occupational-therapy/occupational-therapy-improving-lives-saving-money

Kent Enablement at Home Teams. There are nine Enablement at Home teams, which include a senior and specialist occupational therapist, providing clinical support and advice to supervisors. The teams' purpose is to identify how to reach the most independent outcome for the individual receiving services. They aim to empower support staff to take reasoned and insightful decisions and understand how to work with people to create personalised goals. Simplified and structured paperwork to complement a weekly review of service users' progress ensures the right support is provided at the right time. Improvements are driven by analysis of the recorded data, which ensures issues that could prevent people achieving their best outcome are reviewed at an area and county-wide level. The end results are a reduction in the number of care packages required. 83% of people who go through the service leave it able to live independently at home. This has led to an approximate saving of £3.2 million on long-term support. In comparison to last year, an extra 520 people are expected to leave the service fully independent. The average amount of weekly support for those leaving the service with a care package has reduced by 40 minutes due to improved service user outcomes.

Respiratory Service, Gateshead NHS Foundation Trust. In 2016, the Pulmonary Rehabilitation Team at Gateshead won the AbbVie's inaugural Sustainable Healthcare 'Patients as Partners' award for supporting individuals to take control of their care. The six-week programme, run by an occupational therapist, provides tools and strategies to support people to maintain the activities which are meaningful to them. This team has given people across Gateshead with respiratory conditions (such as chronic obstructive pulmonary disease and asthma) the confidence to lead their own recovery. In a review of the service following a year from discharge, 75% of people have been able to maintain their exercise levels and control their breathlessness. This has resulted in fewer GP appointments, hospital admissions and a reduction in medication. For more information please see the full report Making *Personalised Care a Reality; the Role of Occupational Therapy*

Wigan Council Early Intervention Team. Occupational therapists enable people to be independent and to participate fully in daily living activities through reablement programmes. Their role involves leading and supervising support workers, as well as assessing and reviewing people with complex needs. This occupational therapy led reablement service was awarded Outstanding by the Care Quality Commission. In 2016 – 2017 91.7% of people no longer required ongoing support once seen by the Early Intervention Team. For more information please see full report *Relieving the Pressure on Social Care -The Value of Occupational Therapy*

Falls Response Service in Lancashire. In a 12 months period 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 preventative measures. 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. For more information please see full report *Reducing the Pressure on Hospitals. A Report on the Value of Occupational Therapy in England*

The Plymouth Community Crisis Response Team is a multidisciplinary team operating seven days a week. Occupational therapists pick up referrals relating to activities of daily living, personal care and mobility. Within two hours, an urgent care assessment is carried out and an intervention plan is put in place to provide advice, information and support, a care package and/or equipment. The occupational therapist can also assess a person's moving and handling risk and put in place a falls management plan. The team measures effectiveness by looking at occupation and quality of care outcomes, assessing a person's ability to return to their normal routines with the usual levels of dependency and confidence previously shown, as well as the timeliness of the team's response and any resulting reductions in hospital admissions. The Plymouth team sees an average of 1,200 referrals every year, with approximately 88% of referrals not resulting in admission into hospital. With the average cost of a non-elective hospital admission running at £2,888 per person, that success rate gives rise to potential savings of over £3m per year (£3,049,728) as well as freeing up capacity within the urgent care pathway. For more information please see full report *Reducing the Pressure on Hospitals. A Report on the Value of Occupational Therapy in England*

5. **Do you have any examples of good practice that you can share with other sites to assist with delivering the suggested service requirements?**

Multiple examples are included in this submission and can be shared with other sites.

6. **Referring to the proposed metrics section of each of the services described in this document which measurements do you feel are moist important in monitoring the delivery of the specification?**

The only metrics section that mentions more than the number of items achieved, is the Personalised Care service which describes both number and quality of these plans/services. Truly personalised care would measure whether patient identified goals have been achieved and we suggest that this would be the most important metric. Patients everyday concerns usually focus on non-medical items such as whether they can look after themselves and their homes (their activities of daily living), whether they can manage their social activities (contact with family and friends) and whether they can still do the activities that make life worth living such as gardening, time with grandchildren, reading. The right metrics could establish whether the services described help patients reach these everyday life goals. Occupational therapists leading, advising and enabling social prescribing to have done this in the following examples:

Ways to Wellbeing service, York. This multi-disciplinary service created and set up by an occupational therapist supports people to address their health and wellbeing, acting as a bridge between primary care and the voluntary sector. The team works with people who have poor mental and physical health, low mood and anxiety, but are not in crisis. The team, based in GP surgeries uses a social prescribing approach to look at meaningful goals for people, in support of improving their wellbeing and health. They address issues such as housing advice, debt support, counselling links, loneliness and support with long term physical health complaints. They consider people's interests, values and strengths, and use these to help increase social interactions. The focus is on social compassion, social confidence and social connectedness. Over a two-year period, 80% pf patients using the service report greater wellbeing and 75% have increased confidence. A review involving GP practices showered a 30% decrease of GP appointments in people using the service. https://www.yorkcvs.org.uk/ways-to-wellbeing/

The Salford Social Prescribing Hub. Occupational therapist Sarah Bodell and colleagues has developed a hub and assessment tool that is designed to guide link workers through a person-centred approach, to get the most out of the person they are working with, and to identify the best action plan for the person at a particular time. The tool, as well as its underlying framework and model, is based on Occupational Science, which is the theory underpinning occupational therapy. They believe that occupational science has something to offer social prescribers, as it is about identifying activity that is meaningful for the person. Informed by the theory, the model and tool that can be used by a range of practitioners. It is intended that this tool and the accompanying training will build the skills and enhance the toolkit of social prescribing practitioners, whatever their prior level of experience. They believe that working collaboratively and sharing profession specific knowledge is a matter of doing occupational therapy differently. They also recognize that what the person needs at a given time will depend on the complexity of their lives and needs, and that social prescribing services may not fully provide for all their needs at that time. The tool and model therefore also assess whether to refer to more complex services or professionals where appropriate. There will always be a need for occupational therapists in this landscape, and we see them as working to the top of their license with the most complex people. http://hub.salford.ac.uk/ssph/our-projects/.

Pathfinder Clinical Service, Sussex Partnership NHS Foundation Trust. This service offers easy access to mental health support and helps to form a bridge between statutory and non-statutory services to improve patient's experiences. The occupational therapy led clinical

element of the alliance provides support for patients transitioning out of secondary care, facilitating discharge and also offers proactive, preventative work to prevent escalation of problems and mental health admission. Clinicians (occupational therapists and nurses) spend about 80% of their time with partner organisations, such as Mind and Richmond Fellowship.

Patients who have been supported by the Pathfinder Clinical Service report:

- Better mental health and wellbeing.
- Improved confidence, self-esteem and optimism.
- Fulfilling and meaningful structure to daily routines.
- Improved social connection with others.
- Greater use of other local resources.
- Over a 12-month period the service has made approximate cost savings of £144,900 due to admission avoidance.

For more information: *Getting My Life Back - occupational therapy promoting mental health and wellbeing in England.* https://www.rcot.co.uk/promoting-occupational-therapy/occupational-therapy-improving-lives-saving-money

About the College

The Royal College of Occupational Therapists (RCOT) is pleased to provide a response to this request. RCOT is the professional body for occupational therapists and represents over 31,000 occupational therapists, support workers and students from across the United Kingdom. Occupational therapy enables people of all ages to participate in daily life to improve health and wellbeing. The philosophy of occupational therapy is founded on the concept that occupation (participating in activities) is essential to human existence and good health and wellbeing.

Occupational therapists are regulated by the Health and Care Professions Council (HCPC), and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties. Occupational therapists work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Contact

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