Occupational Therapy and Delegated Healthcare Activities:

Principles in Practice Discovery Workshop.

16 May 2024

Kentmere Community Centre, Leeds.

"Good support isn't just about 'services' – it's about having a life."

Facilitator:
Alicia Ridout, Senior Strategic Improvement Coach, IMPACT Demonstrator Lead for England (Leeds) Integrated Neighbourhood Teams.

Executive Summary

"It's not the hoist, it's the activity the person is enabled to do afterwards that matters".

Following a strategic workshop in February 2024, facilitated by IMPACT Senior Strategic Improvement Coach, it was clear that there was a gap in the system wide planning for the Delegated Healthcare Activities Principles. The occupational therapy services involved in the new home care service due to be piloted from September 2024 in the city were asked to join a workshop. This was aimed at exploring the potential opportunities, barriers, and future requirements that might be needed for occupational therapists to optimise delegation of healthcare activities, improving outcomes for people drawing on home care support.

It was facilitated as part of the IMPACT (Improving Adult Care Together) Demonstrator for England, based in Leeds, focused on Integrated Neighbourhood Teams, and sought to support the national Skills for Care team leading the voluntary implementation of the DHA principles, with a case study.

The workshop used journey mapping and prioritisation exercises to structure the session. The following actions have been proposed:

1. To explore the option of meeting with other occupational therapists and wider groups working to implement the DHA principles, to run through actual case studies and identify changes we can investigate or test locally: A community of practice.
2. Collaborative working with colleagues to influence changes that make the most of occupational therapy and support the governance, improved consistency in delivery, and risk management that delivers assurance for regulated health professionals and people drawing on care and support and their families.
3. Focus on information gathering and assessment parts of the journey map to focus on key areas for improvement (ideas in Appendix 3).
4. Further review of the wider pathways and operational data relating to clinical priorities, to optimise change related effort for people drawing on care and support.

This report forms part of the work encompassed by the Leeds and Bradford DHA Steering Group, led by Leeds City Council, in partnership with health and care providers and commissioners.

Contents

Occupational Therapy and Delegated Healthcare Activities: 1

Principles in Practice Discovery Workshop. 1

Executive Summary 2

Introduction 4

Approach 5

Findings 6

Journey map key insights/issues 6

Journey map priorities: 8

General discussion themes: 8

Ideas and opportunities: 9

Feedback from the Citizen panel: 9

Next steps: 10

Appendix 1 11

Appendix 2 12

Appendix 3 13

Introduction

The workshop was convened as part of the partnership approach being used in Leeds to scope the requirements for effective deployment of the Delegated Healthcare Activities (DHA) Principles, published by Skills for Care in 2023. That guidance had undergone a national consultation and the final version, plus a significant set of resources to support effective use in practice, had been published to support voluntary implementation from 2024 onwards.

Following a strategic workshop in February 2024, facilitated by IMPACT Senior Strategic Improvement Coaches, it was clear that that a gap in the system wide planning for the DHA principles was the occupational therapy services involved in the new home care service due to be piloted from September 2024 in the city.

The DHA principles[1] clearly state that:

"Healthcare activities that are delegated by a regulated healthcare professional must be within the delegating professionals' scope of practice and their professional and regulatory standards. Examples of regulated healthcare professionals (not exhaustive) include registered nurse, nursing associate, occupational therapist, paramedic, speech, and language therapist." (p5)

and

"Usually but not exclusively of a clinical nature, that a regulated healthcare professional delegates to a paid care worker or personal assistant." (p4)

The four principles aim to support a collaborative approach to deployment across pathways of care and organisational boundaries. Many occupational therapists have patients/clients drawing on care and support services in adult social care (ASC) including home care. The occupational therapists may work in the NHS, ASC, as independent practitioners or for charities focused on a particular community of people accessing services, such as multiple sclerosis. They are also involved in Continuing Care provision. Several of the therapists had been involved in the wider Demonstrator project which was seeking to deliver a shift-based, more holistic, and personalised care model. Insights from this wider work informed the preparations for this workshop (see Appendix 1).

The workshop aimed to explore for the first time, the potential opportunities, barriers, and future requirements that might be needed for occupational therapists to optimise delegation of healthcare activities, improving outcomes for people drawing on home care support.

It was facilitated as part of the IMPACT (Improving Adult Care Together) Demonstrator for England, based in Leeds, and focused on Integrated Neighbourhood Teams.

[1] https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Delegated-healthcare-interventions/Delegated-healthcare-activities-and-the-commissioning-of-adult-social-care.pdf

Approach

A small group of occupational therapists was convened, from the Active Recovery team (Leeds Community NHS Trust), Continuing Care (West Yorkshire Integrated Health and Care Partnership) and the new Community Health and Wellbeing Service (CHWS) commissioned by Leeds City Council ASC.

The group had reviewed the published documents and audio-visual materials provided by Skills for Care and joined a briefing by the facilitator (also an occupational therapist) who had undertaken some preliminary research in keeping with the IMPACT[2] model:

"IMPACT is the UK centre for implementing evidence in adult social care. Working across the four nations and with co-production at its heart, we draw on insights from research, lived experience, and practice knowledge to make a difference to front-line services, and to people's lives."

1. Published Evidence
   A brief literature search did not reveal a clear body of evidence or guidance for occupational therapist. Canadian occupational therapists use the term 'task-shifting' which surfaced a paper outlining some contextual issues. Largely the evidence and Skills for Care published guidance was focused on Nursing and therefore highlighted a gap in the evidence based.

2. Practitioner Evidence
   The Royal College of Occupational Therapists (RCOT) Principal Occupational Therapists national community of practice were contacted to share a request for information via their Padlet online system. The participants in the workshop were also unaware of other groups in their networks working on this area of practice. The regional manager for Skills for Care who was also in attendance, was similarly unaware of occupational therapists elsewhere in the region working on this topic. It was agreed to widen the 'call' and ensure all the workshop outputs were shared.

3. Lived Experience
   The workshop included the outputs, including persona, from a series of Citizen panels that had been generated to support the new CHWS and the DHA strategic work. A graphic artist was also present and captured a summary of the deliberations and discussions from the workshop. These were shared with the subsequent Citizen Panel to garner their views and maintain their experience as a central tenant of the work.

[2] https://impact.bham.ac.uk/

Findings

Journey map key insights/issues (see Appendix 2)

The participants divided the journey of a typical citizen pathway through to the current ASC provision of home care, mapping their activities into this and identifying issues and risks. The pathway is not linear but can cycle as citizen needs change or referrals return due to changes in function/levels of need or a new diagnosis that impacts current care. The journey was also reviewed against the Citizen panel persona to surface other insights.

1. *Referrals:*

- Wide range of sources, sometimes from other occupational therapists, for equipment they may not be able to issue/order.
- Flow is impacted by backlogs, for example in Social Work which means the situation/needs may have moved on from the initial referral (which could have been a simple DHA appropriate task).
- Reasons for referral are often: seating, pressure care, management of contractures, moving and handling needs (such as hoisting) neurological conditions, and other long term management needs (frail elderly), falls prevention/management or fast track continuing care related needs – these are treated as a top priority. Many people now also have mental health needs.

Key message: The diversity of occupational therapy referrals and complexity of peoples' needs means a one size fits all list of activities to delegate may not be the best route to effective deployment of the principles.

2. *Information gathering:*

- Meeting response times when a decision is required within a specific time and getting good information is difficult – informal carers not available, poor information in the referral, lack of access to live information about the person, limited shared sources of information to get the best picture.
- Anger from families when contacted for clarity about the need and a lack of choice in the process.
- Consent/capacity assessments unclear how current/what they understand is happening with their care.
- Record systems being siloed and separated for occupational therapists working across systems of care is a significant barrier. One therapist cannot review another to build on for example rehabilitation goals. Transfer of DHAs across the system is also a challenge (people moving between health and care providers while living at home, receiving services).
- Managing team relationships while needing to screen referrals or discuss with wider multi-disciplinary teams (MDTs) – complexity can be the person/diagnosis or their circumstances.
- Persona review with 'Vicky' (below)revealed issues with involvement in and communication of any triage, waiting for an assessment by an occupational therapist (can be 6 months) at which point she may not have reached the threshold for a service.

Key message: Consideration of potential DHAs needs to take place at an earlier stage and better access to information is a key foundation in this aspect to optimise scare occupational therapy resource and opportunities for care workers to pick up DHAs.

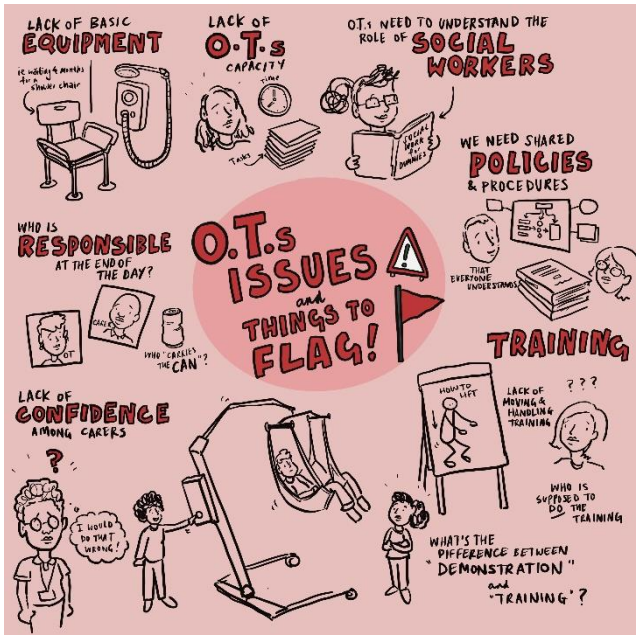
3. *Assessment:*

- A series of challenges with the early stages of assessment, for equipment, large and small which could impact delegation of for example the use of smaller/simpler equipment to support recovery, rehabilitation, or adaptation (with deteriorating conditions).
- Aligning what is important to the person to achieve, and what may be advised by others in the care team or assessed as needed by the occupational therapist (carrying out evidence-based interventions), is a challenge. Potential for delegation is a complex decision in these contexts.
- Assessments for people also using home care can vary from one community team undertaking a 2-hour assessment with multiple standardised tools, to a short visit to support another member of the MDT.
- Language and communication needs were a frequently cited need, with joint working with MDT members at assessment at the heart of effective, collaborative working. Terms used should not assume implicit understanding (such as DHA) and need to be routinely captured as an open, two-way conversation. This is difficult with notes being siloed and a push to online records, inaccessible to people drawing on care and support.
- Assessed needs not being met due to equipment waiting lists, lack of trained care staff, difficulties meeting face to face with carers to delegate activities and check competency regularly – reducing confidence in DHAs as a safe practice.
- Managing risk in a context of agreed DHAs where consistent performance is more likely to fail if this over relies on one care worker or an informal carer. Mitigations to manage this are challenging as there is no risk register (unlike the NHS which uses for example Datix).
- Making recommendations based on a current situation knowing they may not be deliverable if equipment waits are long, care needs are fluctuating, care workers are changing regularly, and training will be impossible to assure (regarding outcomes for the person).
- Dissemination of assessment outcomes can be complex if things have changed during delays/waits, meaning referral back into some services or new service referrals onto other specialities. It can be a fast-moving situation where DHAs may need revising/retraining or halting.

Key message: Closer MDT working is needed to assure person centred interventions that can be delivered. Joint working is not duplication of effort but for some people with complex physical, mental wellbeing, and social needs, an essential element of safe and effective DHA decision making for occupational goals and fluxing conditions.

4. *Discharge/referral on*:
    - Very few of the people referred to ASC occupational therapy are recipients of ongoing therapeutic interventions/rehabilitation care plans. Signposting to other services or referring on are more usual. This was the least discussed area of service provision.
    - There was a lack of clarity relating to how competencies could be reviewed, checked, or changed if people were no longer 'on their caseload' as is usual practice, once assessed and the recommendations form an assessment, completed.
    - Some points were discussed about DHAs where an informal carer may be carrying out tasks at home, and where accountability and responsibility for reviews lies across all DHAs.
    - End of life is a priority, with Continuing Care occupational therapist leading Fast track needs with colleagues.

Key message: How will DHA reviews fit with current capacity and set targets for performance/waits?



Journey map priorities:

3 stars: Lack of basic equipment provision resulting in higher levels of need; Different systems for IT.

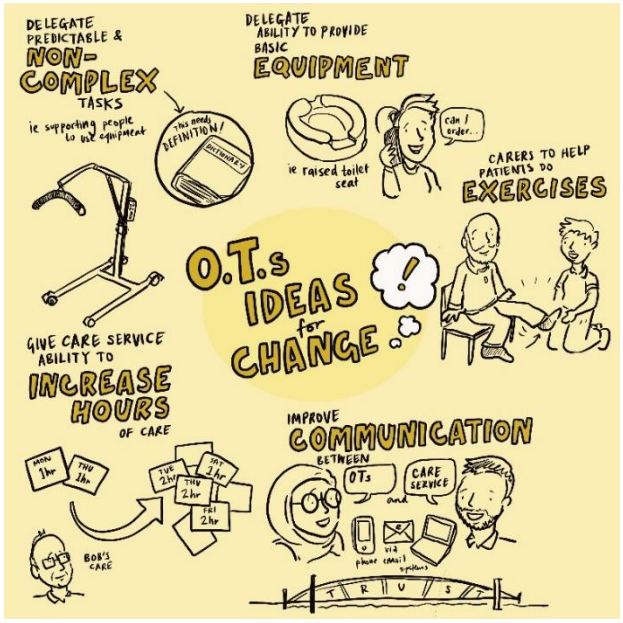
2 stars: Lack of training in moving and handling; Not enough OT capacity to meet demand; Ots developing knowledge of traditional social worker roles such as PoC.

1 star: Governance of DHAs; Who's responsible for moving and handling skills; What is the expectation regarding keeping people on an (OT) caseload until there are further needs; Sharing (or not) documentation; Understanding care agencies training and actual competencies; People like persona Vicky, not involved in the triage decision; equipment availability; Developing shared policies, practices, and training.

General discussion themes:

1. Communication – We can't do this work until we can fully access Leeds care record and the summary care record where we can write into it, not just read it. Can we learn from other work being undertaken like this (not called DHAs)? How can we share our learning? We need the new model awareness raising communications soon.
2. Equipment – Staff are buying people small equipment themselves as its not available and the citizens needing it now, don't have the means. How can we bridge this gap in provision to deliver DHAs? Can we make equipment provision more independence focused?
3. Training – Companies training is inconsistent. What is the difference between demonstrating and competency training in reality? Time/capacity? If staff don't use a skill every day, they will lose the competency.
4. Culture – Can we change care for a person put on a full care package due to systems pressures, with no reablement? Care is compensation focused, not independence focused. The new CHWS is also prevention focused but we are not set up for this, due to the scale of demand. Where does the E & QIA service assessment sit with this work? Can we map the many initiatives to better understand where the improvements might be? E.g., Waiting Well?

5. Information systems: Link them so we can get alerts about a change in need, issue with equipment, change in function that might stop an admission if we can pre-empt it. Care plans need to reflect quality of life and be holistic.
6. Risk – What about people with no support network or family? What about capturing incidents and near misses? Who will spot these and record/investigate? How can we use DHAs to better support those discharged from hospital without care, to stop deterioration?
7. Guidance and support: What guidance is there about DHAs and occupational therapy? There is a lack of clarity about what activities could be delegated relating to peoples' occupational performance/goals etc.



Ideas and opportunities:

1. To explore the option of meeting with other occupational therapists and wider groups working to implement the DHA principles, to run through actual case studies and identify changes we can investigate or test locally. A community of practice.
2. Collaborative working with colleagues to influence changes that make the most of occupational therapy and support the governance, improved consistency in delivery, and risk management that delivers assurance for regulated health professionals and people drawing on care and support and their families.
3. Focus on information gathering and assessment parts of the journey map to focus on key areas for improvement (ideas in Appendix 3).
4. Further review of the wider pathways and operational data relating to clinical priorities, to optimise change related effort for people drawing on care and support.

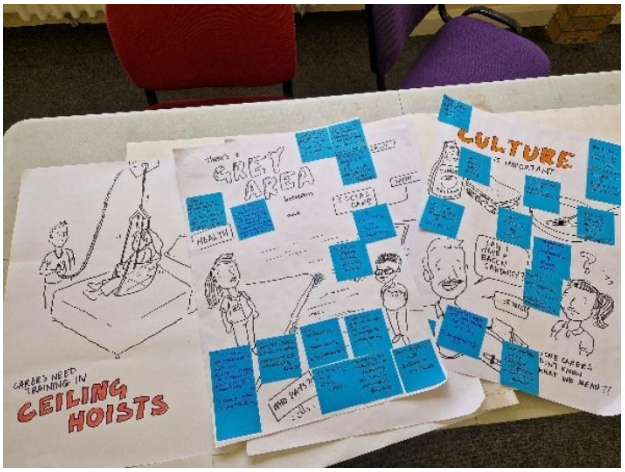
Feedback from the Citizen panel:

The panel met the week after the workshop and reviewed preliminary feedback from the day. They felt that baby steps were required for this work, a sentiment echoed by the occupational therapists. The panel also felt that the tasks likely to be delegated needed to be explored and agreed with them, not for them, and that they should be directly involved in the training and sign off of competencies,

have easy ways to share feedback with the occupational therapists if it was not working, and retain a holistic view of their entire care package, not just one professional group. Hoisting was an area of particular concern to the panel members, who are full time wheelchair users.

Concerns for example, related to the prescribed use of for examples slings, based on a generic practice guide by the manufacturers and implemented via occupational therapy demonstrations to care workers (not training), who then applied this based on their brief online training in generic hoist use. The online training might be relating to those that are not ceiling fixed and require different approaches. The risks of this were cited as for example, being left with damaged skin, especially when a sling was left in situ for a long period, by the care worker team. Clarity regarding responsibility, accountability, flexible/personal adaptation of best practice with the persons consent were a priority.

This example provided insight into the potential complexity of occupational therapy use of delegated healthcare activities and was largely echoed by the occupational therapists themselves.

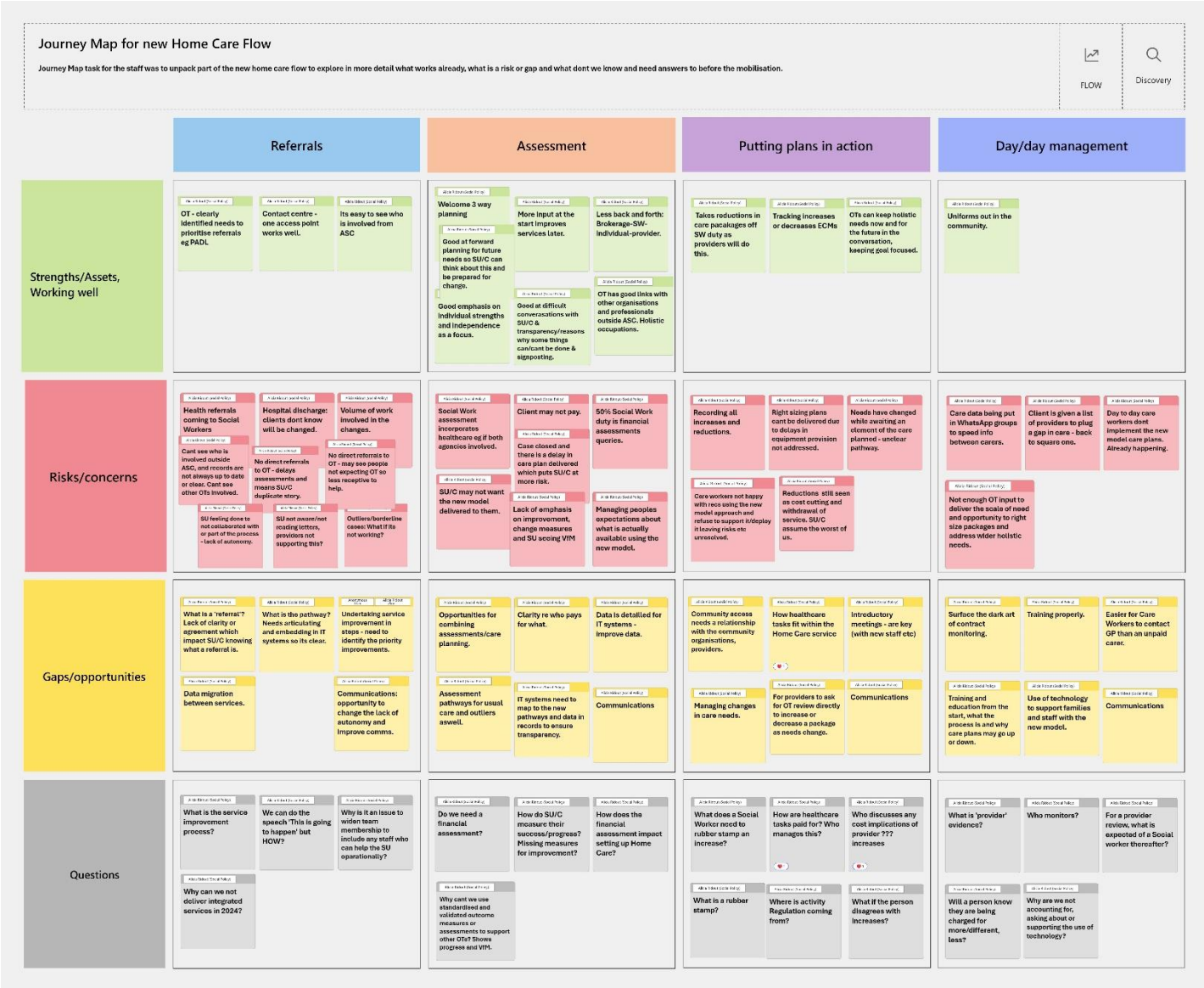


Next steps:

The outputs from the workshop sought to generate a case study for Skills for Care team implementing the principles across the UK. It also provided additional insights for the wider Leeds and Bradford Delegated healthcare Activities Steering group, providing a deeper dive into professional opportunities that might be adopted moving forward. The Steering group will retain the transformation lead role for the DHA work, for all regulated health professionals and care staff.

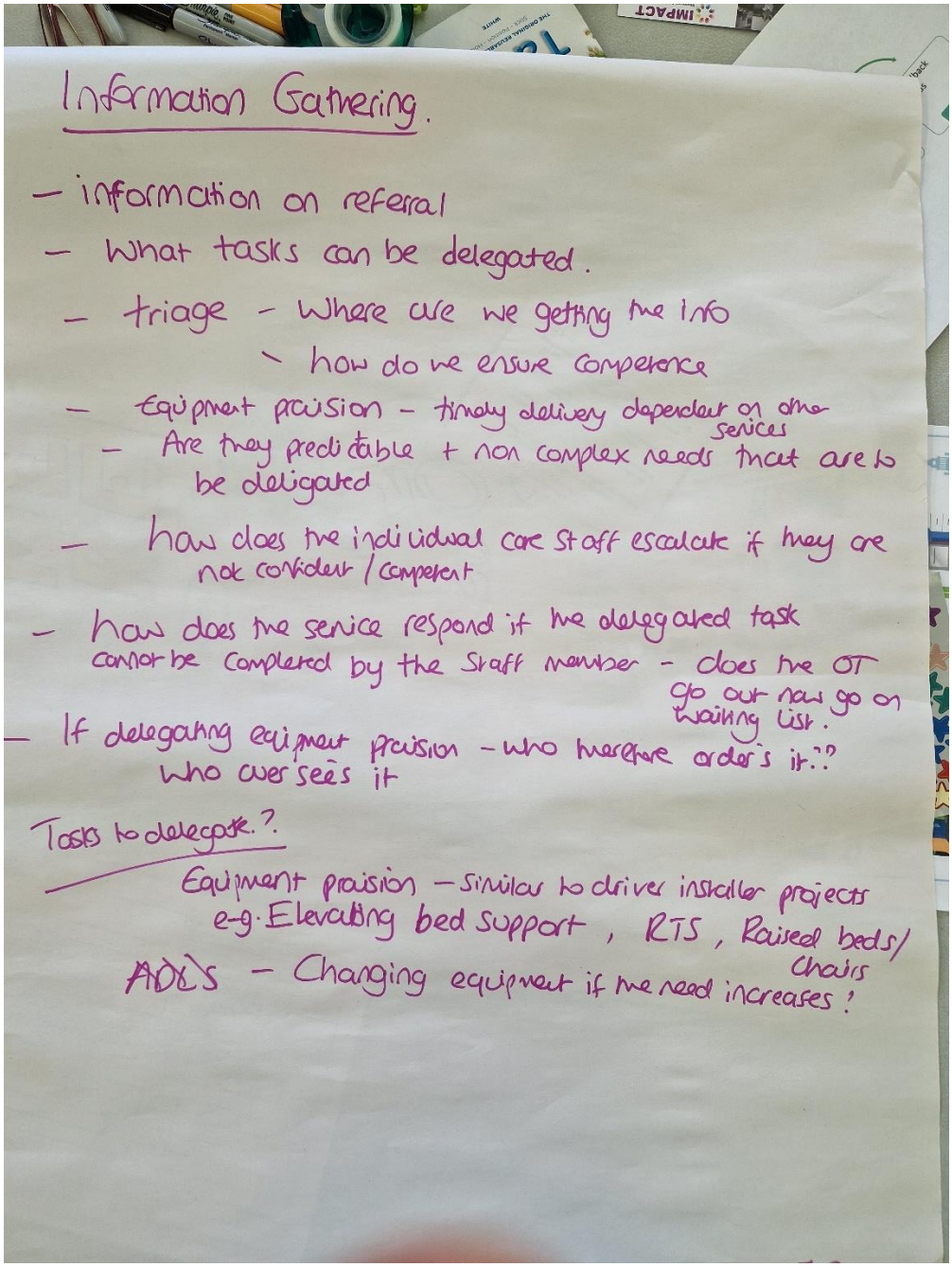
The workshop has been a springboard for national work, linked to Skills for Care and RCOT to support guidance generation based on a stronger evidence base, mapped into new models of home care such as the Leeds pilot. The IMPACT team will continue to support the sharing of learning and insights from this, and other work undertaken between 2023 and 2024 in support of service improvement planning for the pilot, commencing in September 2024.

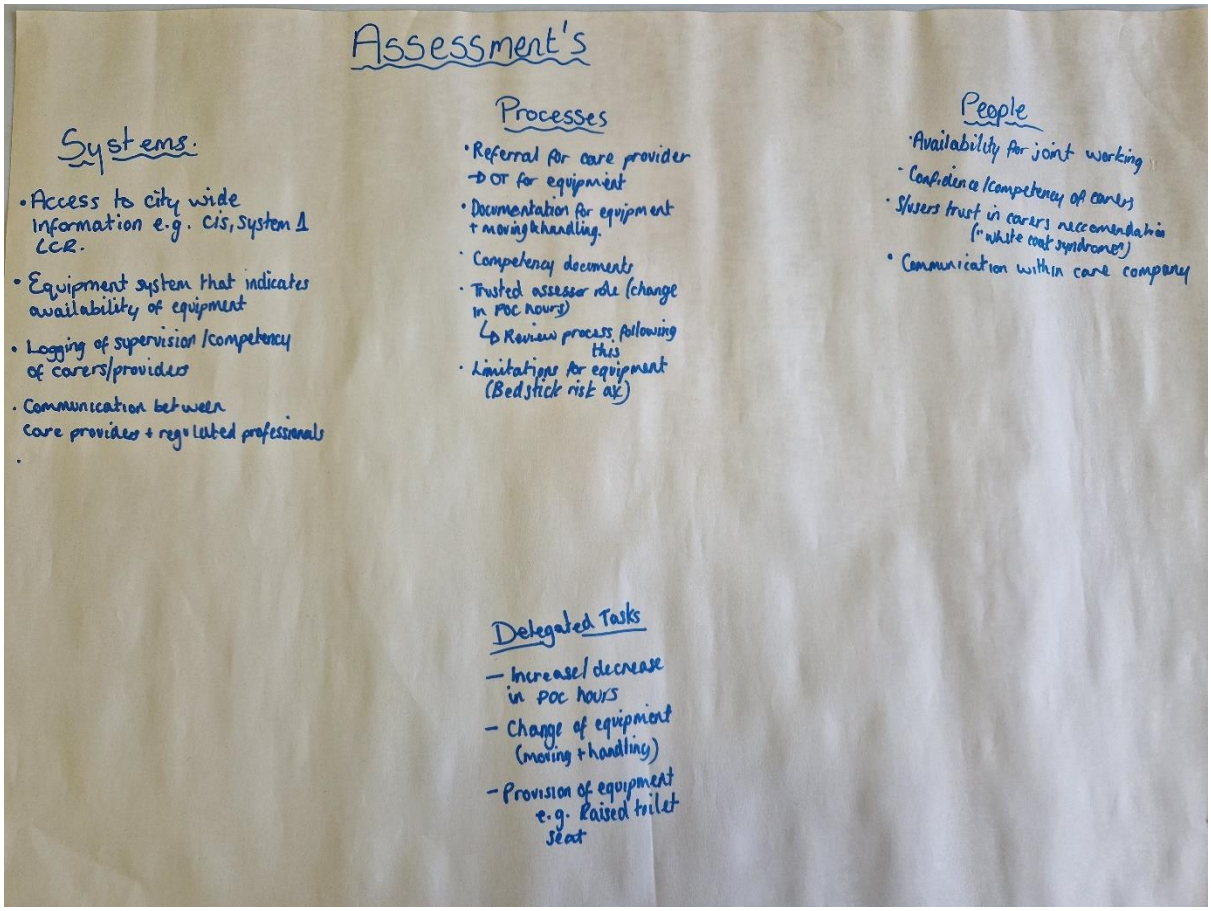
Appendix 1 - Example of wider insights from the demonstrator project, informed by occupational therapists and social workers:



Appendix 2 Assessment to Discharge (top to bottom).

Appendix 3 – Ideas for improvement.




Assessment's
Systems
• Access to city wide information e.g. CIS, System 1 LCR.
• Equipment system that indicates availability of equipment
• Logging of supervision / competency of carers/providers
• Communication between care providers + regulated professionals
Processes
• Referral for care provider → OT for equipment
• Documentation for equipment + moving & handling.
• Competency documents
• Trusted assessor role (change in POC hours)
↳ Review process following this
• Limitations for equipment (Bedstick risk ax)
People
• Availability for joint working
• Confidence / competency of carers
• S/users trust in carers recommendation ("white coat syndrome")
• Communication within care company
Delegated Tasks
– Increase / decrease in POC hours
– Change of equipment (moving + handling)
– Provision of equipment e.g. Raised toilet seat