Proactive Care – Occupational Therapy in a General Practice Pilot Project November 2015 – June 2016

Summary

General Practice has been described as the cornerstone of the National Health Service, but is widely acknowledged to be under significant pressure. One factor is an increasing older population with multiple and complex health and social care needs. The added value that other healthcare professions, including occupational therapy, bring to General Practice is increasingly recognised as part of the solution to maintaining and improving patient care within our local communities.

A new way of working has been piloted by Hywel Dda University Health Board occupational therapy service working with Argyle Street Practice in Pembroke Dock, which involved embedding an occupational therapist in the practice, introducing an alternative, proactive model of care.

Demonstrable benefits included;

- Reducing demand on general practitioners by addressing and resolving underlying issues that are the root cause of multiple and regular contacts.
- Releasing GP's, practice and community nursing staff time to focus on doing what only they can do.
- Proactively resolving health and social issues at an early stage, minimising crisis situations that result in presentation/admission to the acute hospital
- Sustaining people at home following discharge from hospital.
- Reducing falls, improving safety and confidence enabling people to engage in daily life.
- Releasing professional capacity by enabling people to maximise their own potential, promoting self management, preventing ill health and dependency.

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Future opportunities were also identified;

- Reducing demands on GP's by an occupational therapist visiting at home instead of a GP, where functional decline is identified as a primary concern.
- Enhancing OT knowledge to support GP's by identifying and communicating signs of ill health, avoiding escalation to point of crisis.
- Broadening remit to incorporate other identified groups

The project was well regarded by the GP's, practice staff and patients with improvements in communication being valued, improved outcomes for patients being recognised, as well as the realisation that GP's and nurses capacity can be released to focus on doing what only they can do, with the added value of an occupational therapist within the team.

"The OT manages frailty issues much better than me!" - GP

"Felt I had someone to contact" - Patient

Situation

General Practitioners (GP's) and practice teams are at the heart of our communities and the foundation of the National Health Service. Across Wales primary care is the first point of access for more than 90% of the population and the main source of regular medical care.

Primary Care services are widely acknowledged to be under unprecedented pressure and it has become clear that there is a need for change in the way we deliver services. (The King's Fund, 2016).

According to the Citizens Advice Bureau, the rising number of consultations means GP's are spending almost a fifth of their consultation time on patients' non-health issues. (Citizens Advice, 2015).

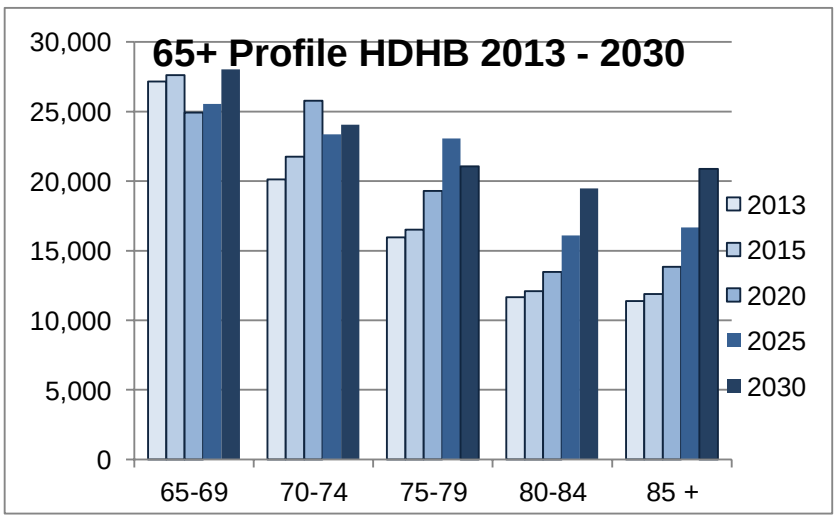
The National Plan for Primary Care Services and accompanying workforce plan identifies the need to invest in the wider primary care workforce, advocating a new focus on inter-professional and multidisciplinary working, as well as underpinning principles including;

- Prevention, early intervention and improving health, not just treatment
- Coordinated care where generalists work closely with specialists and wider support in the community to prevent ill health, reduce dependency and effectively treat illness

The Royal College of General Practitioners in Wales recognises the need to expand the "general practice family" as part of addressing the significant challenges faced in general practice. Strengthening General Practice, (2015) identifies an urgent need to address the skill mix and recognises the unique skills and added value of other health professionals in improving health outcomes for patients.

The British Geriatric Society "Silver Book", Quality Care for Older People with Urgent & Emergency Care needs, identifies that approximately 95% of urgent care is delivered in primary care. Underpinning principles advocate that interdisciplinary working with a person centred approach provides the only means to achieve the best outcomes for frail older people with health and social care crises

The Health Board's Population Health Group report on Frailty and Dementia reminds us that, whilst the current local age profile generates a challenging demand on services, age projections for our local population indicate a growing problem.



The report identifies that the majority of older people have multiple physical and mental health needs which require input from across primary care, secondary care and social care. For older people living with frailty or complex needs, health and quality of life is vulnerable to sudden changes and a 'trigger event' can result in a rapid deterioration in health and significant loss of independence. This will include people who could otherwise be very stable and low users of health services.

The College of Occupational Therapists advocates that;

> "Occupational therapists can support the work of GPs by offering proactive input to help people manage their conditions, stay as active as possible and continue with their daily lives. They can also work in partnership with other professionals to help respond to crises in the home and prevent unnecessary hospital admissions".

"Transforming services for older people requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time." (King's Fund, 2014).

Background

In Hywel Dda University Health Board, occupational therapy services are accessed as part of secondary care, community resource teams and via social care & housing. Referrals, however, are frequently received at point of crisis and people often have to wait a number of weeks for a routine assessment. Intervention and impact is commonly remote from GP's who hold the responsibility for the ongoing primary support.

In October 2015 there was an opportunity to explore with general practice clusters an alternative model of occupational therapy provision. With a patient caseload in excess of 25,000, a large centralized hub and a proactive and motivated GP workforce Argyle Street Practice was viewed as an ideal site for a pilot project.

In November 2015 the project commenced with funding being agreed for an experienced occupational therapist (0.9WTE) from the locality team to be embedded in the practice to undertake a period of testing an alternative way of working.

The aims of the project were defined and agreed with the practice as;

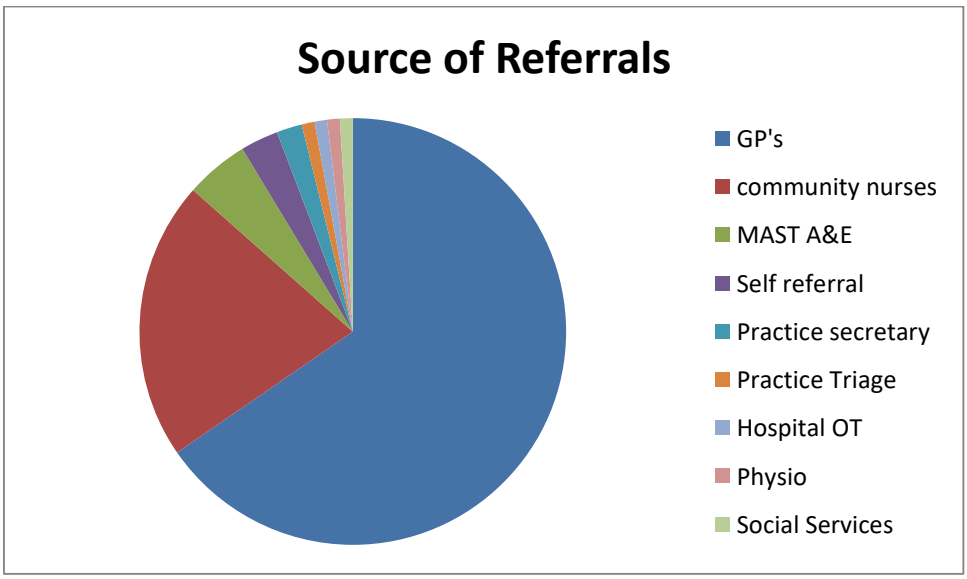
- Using the Anticipatory Care Planning approach, identify patients who are regular users to the service and increasingly frail and isolated.
- Provide proactive Occupational Therapy intervention for the identified group; frail elderly with complex presentation and multiple co-morbidities.

Project Outcomes

From November 2015 to May 2016 the occupational therapist saw 104 new patients, an average of 15 each month, ranging from 6 in the first month to 21 new patients in January. Patients seen had an average age of 80 years and 62% were female.

People were seen on average within 2 working days, ranging from same day response to six days for one non urgent referral whilst the OT was on leave. Each new patient was seen by the occupational therapist on average four times.

An additional 39 patient queries from GP's were received and advice/signposting provided by the occupational therapist.

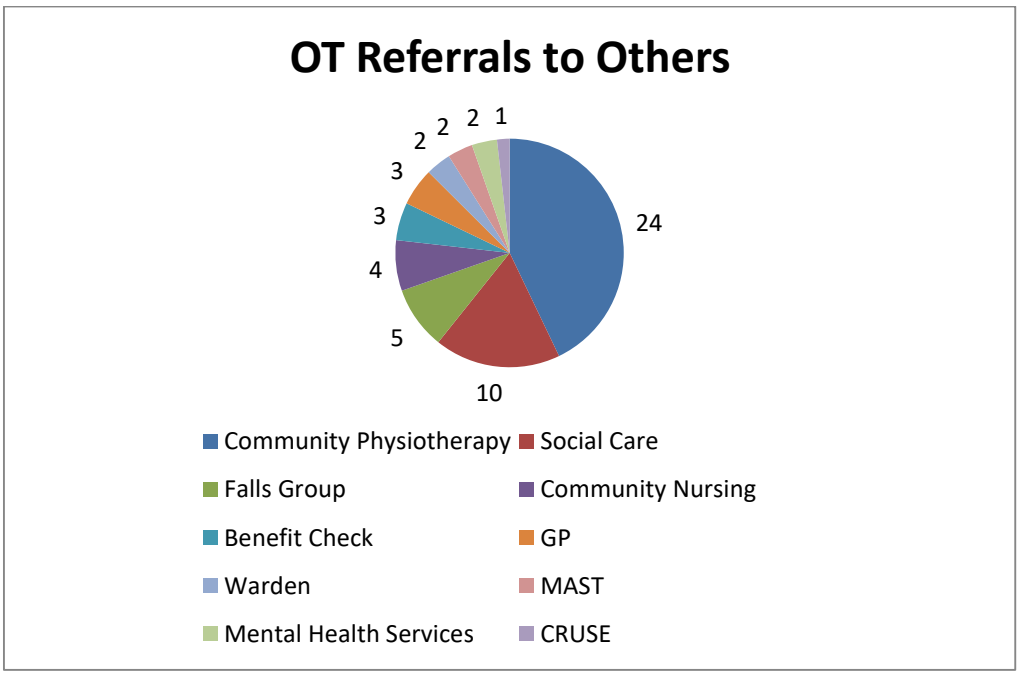


There were sixty- eight referrals from GP's within the first seven months of the project. This contrasts with thirteen GP referrals from the practice to the community occupational therapy service in the six months preceding the project.

All of the referrals to the occupational therapist from the practice resulted from a request for a GP home visit. The GP identified following their visit a primary concern of functional decline and referred on to the occupational therapist. With increased confidence in the occupational therapist's skills, the initial GP visit could potentially have been undertaken by an occupational therapist.

The Occupational Therapist requested one GP visit with a subsequent diagnosis of a heart murmur. There is potential for occupational therapy skills in primary care to be further enhanced to identify ill health and proactively communicate this to GP's, preventing escalation to health crisis.

The occupational therapist undertook a range of interventions with all 104 patients seen, i.e. rehabilitation programme, prescription of aids & home adaptations, advice, enabling techniques, supporting self management of conditions, working with patients to facilitate change and engagement with other services.



What Difference did we make?

Reduced contacts with surgery

From a random sample of 7 patients seen by the occupational therapist, the surgery identified that contacts with the surgery reduced.

Age of patient	Nov 50	Dec 93	Jan 86	Feb 87	Mar 87	April 59	May 78
GP/surgery contact one month prior to O.T intervention	14	5	5	9	7	4	3
GP /surgery contact one month post O.T intervention	7	0	2	1	2	1	0

"A few patients I have seen, who were serial requestors of visits, have reduced their requests after OT intervention".

"Several patients with acute issues seen within a few days by the OT prevented repeat visits".

Based on GP feedback, the reduction in GP repeat visits was attributed to the occupational therapist's knowledge and skills in assessing and supporting frail elderly patients with complex presentation and multiple co-morbidities, and their ability to engage with appropriate services, resulting in improved patient outcomes. This was surmised by one GP comment in particular:

"The OT manages frailty issues much better than me!"

Supporting people to remain at home

Fourteen patients avoided an acute hospital admission following assessment by the occupational therapist, based on GP's opinion.

Six patients who had experienced a hospital admission were followed up by the occupational therapist once home. Five reviewed four weeks post discharge confirmed none had been re-admitted & there had been two contacts with GP.

Reducing falls, improving independence & confidence

Following OT intervention;

- 81% of patients reported increased safety and confidence in their ability to undertake everyday functional activities.
- 19% reported no change in functional abilities, but carers reported feeling more able to manage.

Thirteen patients were seen who had experienced 3 or more falls;

- 100% reported increased confidence & feeling more safety conscious about reducing their risk of falls.
- 12/13 patients reported no falls in 4 weeks following occupational therapy intervention.

Patient Examples:

88 year old female who lives with her son was referred by a District Nurse requesting a wheeled commode. OT assessment identified the patient had taken to bed for the past 10 days. OT issued a commode to address the urgent need, however OT went onto discuss consequences of pressure damage & immobility with the patient. Written information was provided & a plan agreed to promote the patient to return to her normal daily routines. OT visited next day to facilitate her sitting in chair and agreed a programme to gradually increase her sitting out of bed. Within a week sitting tolerance had returned to 8hr+, and a programme over following 2 weeks resulted in her regaining her mobility within 3 weeks.

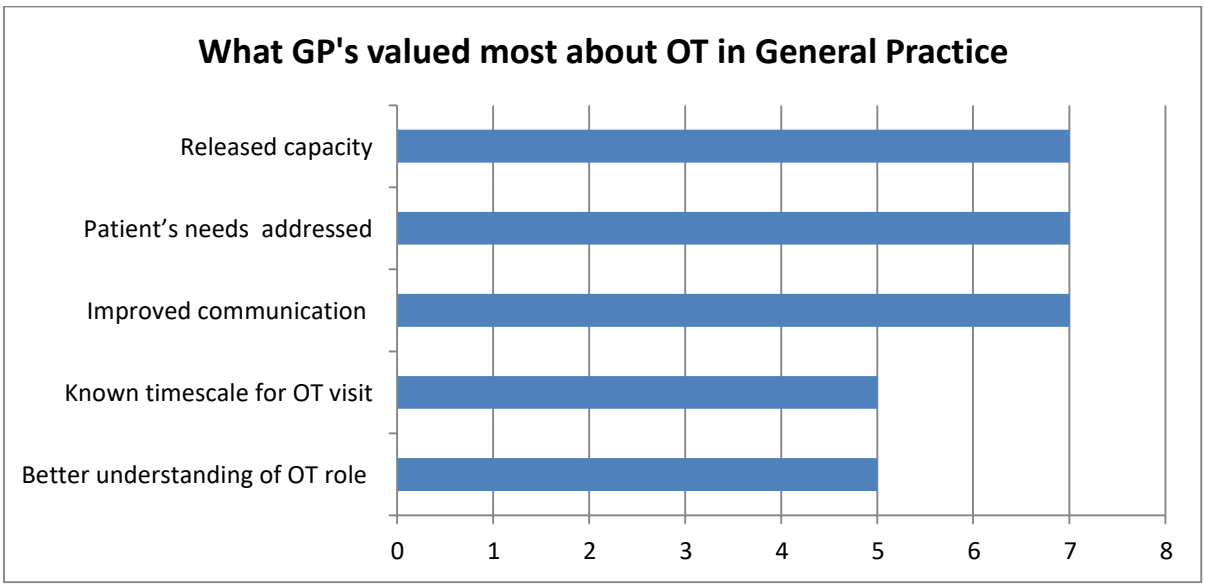
93 year old male who lives with his son had 2 recent falls. GP visited in the morning to rule out a fracture and was able to inform them on his visit that the OT would be

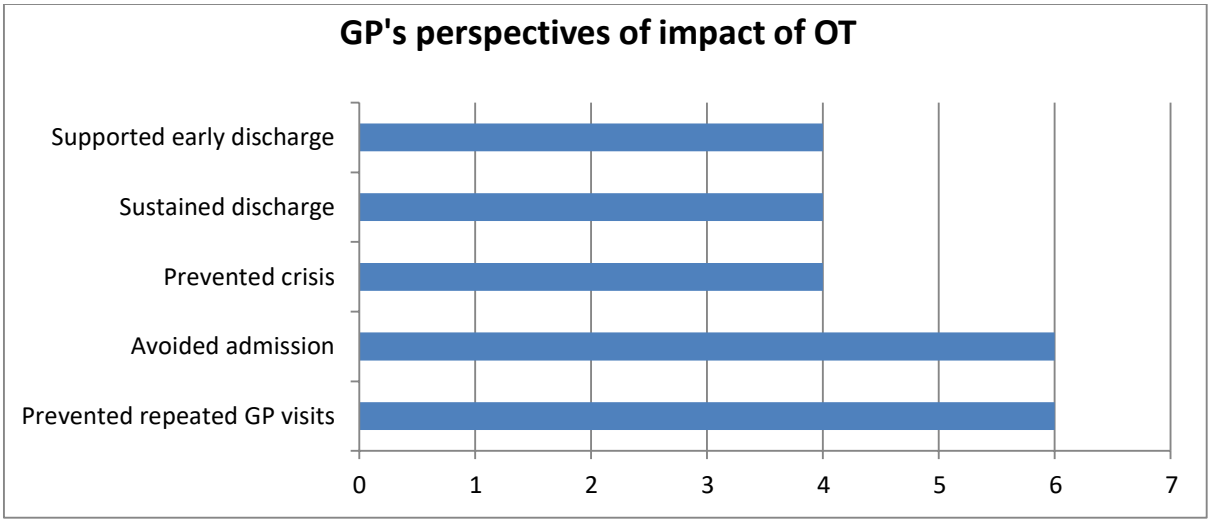
visiting. The OT visited later the same day. Both falls happened upstairs and an inappropriate walking aid was identified as a causal factor. OT assessment: correct walking aid issued; advice, strategies & assistive equipment for safer transfers. Referral undertaken for 1:1 balance program, commenced within a week, then completed with son daily. OT visited to discuss social isolation and promote inclusion, input successfully undertaken to encourage patient & his son 53yr to engage in community. No further falls to date.

79 year old male who lives with his wife. Family requesting GP home visit as his wife unable to cope with his care needs following her recent fall. OT was asked to visit instead of GP. Advice & assistive equipment were provided to enable safe functioning and referrals made re benefits and additional support. Wife physical needs addressed but she was diagnosed with UTI and subsequently admitted to hospital. OT maintained contact with hospital staff and supported wife to return home within 7 days, “community pull” enabled a timely return home. Reviewed post discharge and both managing well at home.

Feedback from the Practice

8/10 questionnaires were returned from GP’s.





GP comments focused on improved communication with '*excellent multidisciplinary working'*, improved '*feedback*' and '*signposting*', with it being '*helpful to have OT on site'*.

Timely and *'holistic'* intervention was also detailed with OT being a '*useful addition to Primary Care Team*' resulting in '*improved patient care*', with '*patient satisfied and OT enables good link'* and '*was able to sort things out'* resulting in '*reduced admissions'*.

The district and specialist nurses results concurred with the GP's feedback, with comments focussing on released capacity; improved communication, and enhanced teamwork, resulting in improved patient care. In addition this group recognised the impact of the occupational therapist being able to proactively address functional decline was avoiding patients escalating to a crisis situation and thus preventing hospital presentation and potential admission.

Importantly this was further expanded on by the chronic conditions nurse specialist who detailed how proactive occupational therapy intervention with those individuals with complex presentation, had had a positive impact on her practice in terms of releasing capacity, resulting in enhanced provision of patient care.

Unsurprisingly, in response to whether GP's and nurses would recommend this model of Occupational Therapy provision there was a unanimous response of "yes" from all questionnaires with additional comments that this is an '*invaluable service'* and '*essential in this time when resources are limited'.*

Feedback from Patients

The practice undertook a questionnaire with 5 randomly selected patients.

- All patients asked strongly agreed that the service response was timely and addressed their individual needs.
- All patients asked thought the service should continue and would recommend the service to another person.

"Service may prevent people going into hospital" "It may stop people falling"

"I liked the follow-up and telephone contact" "An excellent service"

"Felt I had someone to contact"

Conclusion

Occupational therapists are autonomous, registered healthcare professionals, with a breadth and depth of knowledge and skills incorporating physical, psychological, social and mental health & well-being. They have the experience and proven ability to work effectively across organisational boundaries. They are well placed to adopt an influential and pivotal position to support a broad range of services to promote health and well-being within the community, not only across traditional providers of health and social care but also defined roles in primary care.

Importantly the value and impact of this project has been influenced by an occupational therapist with experience working at an advanced level, as an autonomous practitioner providing person-centred clinical care, encompassing the skills of assessment, examination, supporting diagnosis and treatment of patients. This advanced level of professional competence and confidence is recognised as vital to the successful development of an alternative way of working.

The outcomes are based on a practice population in excess of 25,000; a large centralized hub, and a proactive and motivated GP workforce. It is recognised that outcomes may differ depending on GP practice and location.

During the project there was a significant increase in referrals from GP's to occupational therapy, (from 13 to 68 people within a 6 month period). The project demonstrated the value of proactive occupational therapy within general practice, adding value to the traditional workforce configuration with demonstrable impact for patients and the practice;

- Reducing demand on general practitioners by addressing and resolving underlying issues that are the root cause of multiple and regular contacts.

- Releasing GP's, practice and community nursing staff time to focus on doing what only they can do.

- Proactively resolving health and social issues at an early stage, minimising crisis situations that result in presentation/admission to the acute hospital.

- Sustaining people at home following discharge from hospital.

- Reducing falls, improving safety and confidence enabling people to engage in daily life.

- Releasing professional capacity by enabling people to maximise their own potential, promoting self management, preventing ill health and dependency.

Future benefits were also identified;

- Further reducing demands on GP's by an occupational therapist visiting at home instead of a GP, where functional decline is identified as a primary concern.

- Supporting GP's by identifying and communicating signs of ill health, avoiding escalation to point of crisis, with the enhancement of occupational therapists' knowledge and experience within general practice.

- Broadening the remit to incorporate other identified groups, i.e. supporting return to meaningful occupation/work, working with patients with medically unexplained symptoms, supporting mental well-being.

Some GPs highlighted that with an *'ageing population means worsening mobility and increasing problem*' therefore '*recruit more OTs early to prevent over burdening service'*. Furthermore the potential for future developments and benefits associated with this model of provision was recognised with one GP stating '*if continued a permanent feature then we would build on work'.*

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Acknowledgements:

- The support of Argyle Street Practice for the project and providing data and feedback.
- Sandra Morgan and Hayley Blyth for their initial support transforming the idea into reality.

17/06/16