OCCUPATIONAL THERAPY

FRAILTY PROJECT

TOWNSHIP 1

PRIMARY CARE NETWORK

FINAL REPORT

OCTOBER 2020– SEPTEMBER 2021

Published October 2021

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ACKNOWLEDGEMENTS

The frailty service was funded by **Sheffield Clinical Commissioning Group.**

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Eileen Hall (Programme Manager for Personalisation South Yorkshire and Bassetlaw ICS, NHS Sheffield Clinical Commissioning Group)

The following clinical specialists and experts in frailty/older adults supported the initial and ongoing clinical role development:

Gill Agar (Lead Clinical Specialist Physiotherapist Older Adult Rehabilitation Sheffield Teaching Hospitals NHS Foundation Trust)
Laura Bidgood (Clinical Specialist Occupational Therapist NW1 Primary Care Network, Barking and Dagenham)
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Laura Di Bona (Clinical Specialist Occupational Therapist SAPA 5 Primary Care Network Sheffield)
Helen Blomfield (Trainee Advanced clinical practitioner, Township 2 Primary Care Network Sheffield)

Thanks to the Township 1 Primary Care Network **patients, carers and staff** for providing feedback on the Occupational Therapy Frailty service

EXECUTIVE SUMMARY

Background: On 1st October 2020 an Occupational Therapist (OT) funded by the Sheffield Clinical Commissioning Group started working as part of a frailty service, with the six surgeries in Township 1 Primary Care network. An Occupational Therapy service was set up offering a personalised, holistic approach with patients aged over 65 living with moderate to severe frailty in their own homes.

Project aim: The overall project aim was to maximise patients' independence, wellbeing, and their occupational performance levels, while reducing the pressure on GP appointments.

Evaluation: An evaluation of the Occupational Therapy Frailty Service took place from 1st October 2020 to 30th September 2021. Descriptive and process data was collected describing the patient demographic, referral source, goal attainment and Occupational Therapy Intervention. Patient feedback was gained and referrer surveys were also completed.

Evaluation findings: 190 patients who were referred met the criteria for the Occupational Therapy frailty service, and 136 patients received an 'outreach phone review' (calls made to patients identified as moderate/severely frail). The data identifies diverse Occupational Therapy interventions, with supporting patients in the self-management of their activities of daily living, mobility and transfers, equipment and rail provision and establishing carer support strategies being most prevalent. Clinical outcomes measured using the Goal attainment scale show a high level of clinical effectiveness with all patients reaching at least one of their identified goals.

Subjective feedback from 25 patients suggests a high level of satisfaction with the service, with value placed on the accessibility of the service locally though a familiar route, the Occupational Therapy approach in providing support and connection to other services, and the therapeutic impact of Occupational therapy on patients' self-managing their activities of daily living and overall confidence levels.

Referrers found the service generally accessible, valuing the speed and quality of the service in treating patients with complex presentations. GPs identified that the OT role can have a positive impact on their time, particularly with regard to the Occupational Therapist's knowledge of services available to support patients and their carers. Additional role staff appreciated the support from the Occupational Therapist, and having direct access to refer to the service.

Recommendations:

- There is significant value in continuing the OT frailty service in the PCN and developing the scope and magnitude of the service to include patients living with mild frailty
- There is a need to further publicise and promote the service to ensure all GPs and potential referrers are aware of what Occupational Therapy can offer patients living with frailty
- Direct referrals from patients, reception and additional role staff are also identified as an area to develop in order to limit GP contact and free up GP
- Longer term service development to include OT input working with patients returning to work and living with long term conditions

CONTENTS Page Number

1. INTRODUCTION

On 30th January 2019, a successful Neighbourhood Transformation business case was made to the Sheffield Clinical Commissioning Group (CCG) by Township 1 Primary Care Network (PCN) to provide a service targeting care to frail older adults who are housebound. As part of the initial bid, a Clinical Specialist Occupational Therapist (OT) was funded on a 0.8 contract (4 days a week) for a one year secondment from 1st October 2020 to provide occupation focussed interventions to patients in this cohort across 6 GP practices. This report provides information about the setting up of the Occupational Therapy Frailty service, the types of interventions undertaken to improve patients' occupational performance levels, descriptive details of the patients seen, clinical outcomes, feedback from those receiving the service and also from referrers into the service. This report considers learning from the project evaluation, and recommendations for future clinical and service developments.

2. PROJECT BACKGROUND

The Occupational Therapy model proposed for working into Township 1 PCN supports the service redesign outlined in the NHS Long Term plan (2019) and the Update to the GP Contract Agreement (2020), where expanded PCN teams include a range of additional role health care professionals who are best placed to meet patient need, and shift the balance of work away from GPs onto the relevant health professional.

This was the first Occupational Therapy role of its kind in Sheffield, with a growing number of OT's in Primary Care nationally having a specific focus working in frailty. Emerging evidence (McCabe and Greer 2019, Brooks and Thew 2020) suggests that OTs are ideally placed to contribute to PCNs in providing patient centred, holistic, occupation focussed interventions within participatory and anticipatory models of service delivery. Evidence further suggests that OTs have a unique, specialist role when working with older adults experiencing frailty in Primary Care (Evans 2018). By focussing on the day to day occupations that matter to patients, offering a holistic approach to the physical, cognitive, emotional and environmental factors that impact on patients' occupational roles, OTs add value to current service provision in this context (Royal College of Occupational Therapists 2020)

The OT Frailty service was set up during October and November 2020. The service was publicised using posters and an initial newsletter distributed to surgeries; all practices were also visited to meet with staff and answer questions and promote the service. Due to COVID restrictions impacting on the seconded year, it is recognised that the amount of face to face contact with practice staff was limited.

The service evaluation outlined in this document aimed to identify the distinctive clinical and operational impact of the Occupational Therapy role in the Township 1 PCN Frailty Service has on patients and their carers, GPs, and community partners. Specific objectives for the evaluation were:

- To capture descriptive data on referral rates, referral source and area of occupational intervention
- Identify therapeutic impact on patient identified goals
- Capture patients', carers' and GPs' subjective experience of the OT role
- Establish the impact on GP time

3. SETTING UP THE SERVICE

3.1 PROJECT AIMS AND OBJECTIVES

The overall aim of the Occupational therapy Frailty service outlined by the initial bid to the Sheffield CCG was to provide targeted Occupational Therapy to the frail older population in Township one primary care network who are housebound. The Township 1 PCN covers six surgeries in: Birley; Hackenthorpe; Mosborough; Sothall; Owlthorpe and Crystal Peaks which are situated in the S12 and S20 geographical postcodes in the city.
Specific service objectives were identified to :

- Support patients living with frailty in developing self management strategies to maximize their overall occupational performance, independence, quality of life and wellbeing in their own homes
- Test a person–centred, asset based model for OT practice for the frail older population in primary care
- Incorporate a preventative, or 'anticipatory' OT role when working with older adults living with frailty in Township 1 Primary care network

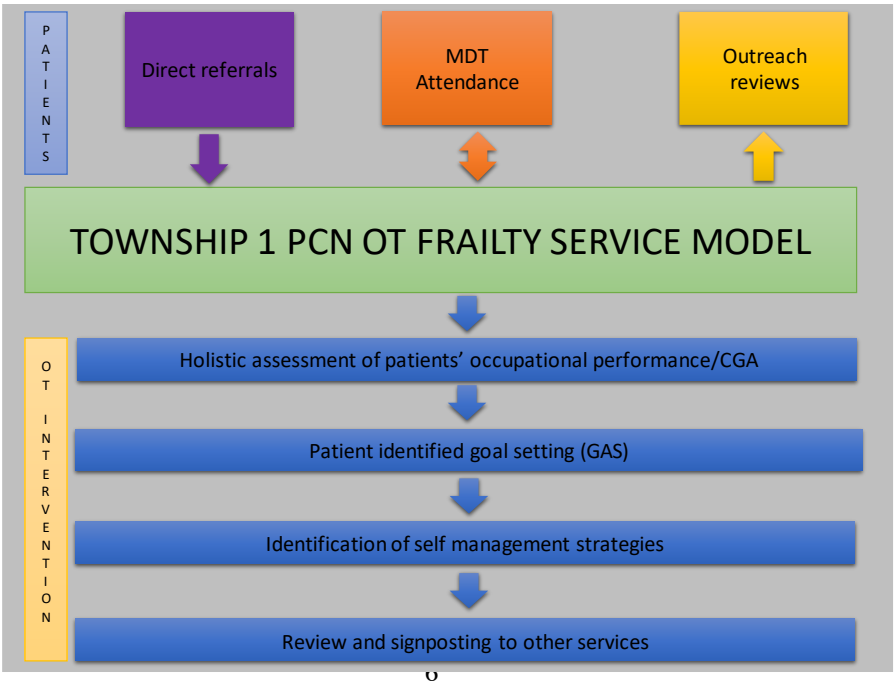
3.2 A NEW OCCUPATIONAL TEHRAPY MODEL FOR FRAILTY IN PRIMARY CARE

A model for Occupational Therapy working with frail older adults was set up (see diagram 1). The model provided three routes of contact into the service

- Direct referrals Staff working in GP practices directly referred to the OT via bookable appointments available on Systmone electronic patient record system. This aimed to use familiar existing systems used by additional role first contact staff.
- Outreach reviews Patients were identified from Systmone frailty/housebound read codes and proactively contacted by phone for screening into the service. This part of the service specifically aimed to identify patients who may not have accessed services/OT before and aimed to enhance the preventative role in working with frail older adults.
- MDT Attendance The OT offered to attend the GP practice MDT meetings, and patients relevant to the service were identified by the OT during the MDT discussion

All patients were contacted initially by phone, and where appropriate visited at home for a holistic, asset based assessment using the personalised care approach, adhering to the comprehensive geriatric assessment (CGA) (British Geriatric Association 2019). Patients were offered OT interventions linked to the assessment outcome and person-centred goals. The Goal Attainment Scale (GAS) (Rockwood et al 2003) was used with patients to identify person centred, meaningful goals and achievement of the goal.

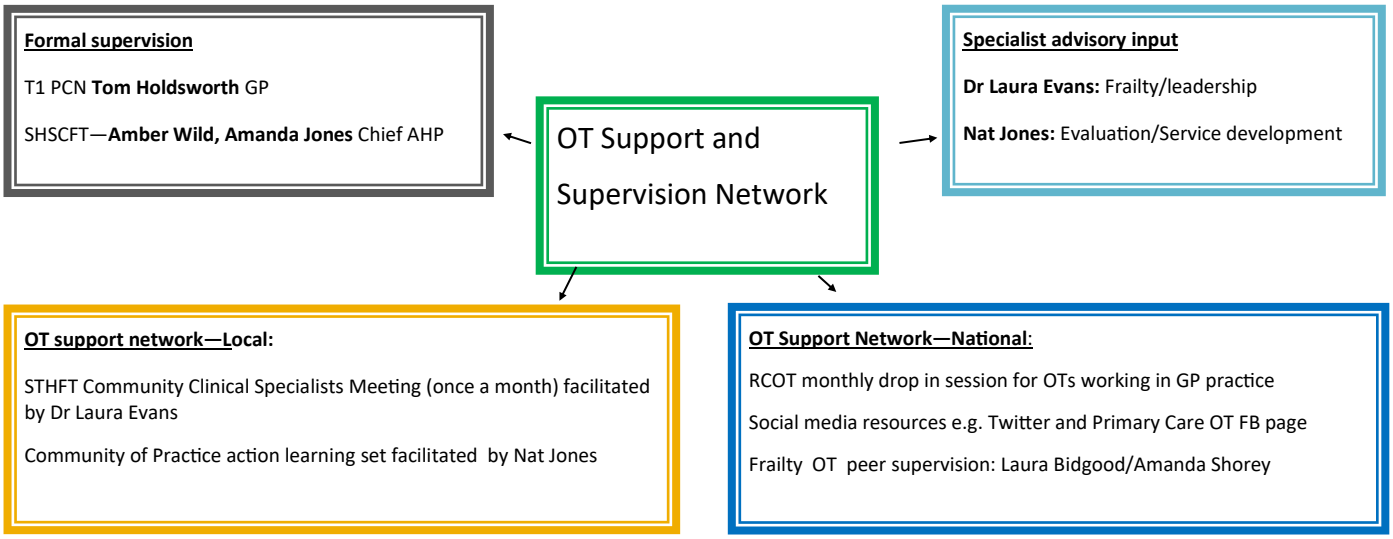
Diagram 1. OCCUPATIONAL THERAPY FRAILTY SERVICE MODEL OF PRACTICE



3.3 DEVELOPING THE INFRASTRUCURE TO SUPPORT THE OCCUPATIONAL THERAPY ROLE

During the initial phase of the project, an infrastructure was developed to support the Occupational Therapy role (see diagram 2). Operational and clinical expertise came from within the PCN, Sheffield Health and Social Care Foundation Trust (SHSCFT), and Sheffield Teaching Hospitals Foundation Trust (STHFT). This support drew upon existing local and national networks . A monthly action learning set was established with two Occupational Therapists working into other PCNs in the city (SAPA 5 and Township 2) as more OTs were recruited. Specialist advice on Frailty and Service development was also accessed locally.

Diagram 2 PRIMARY CARE OT SUPPORT NETWORK



3.4 THE FRAILTY SERVICE:AN INTEGRATED APPROACH

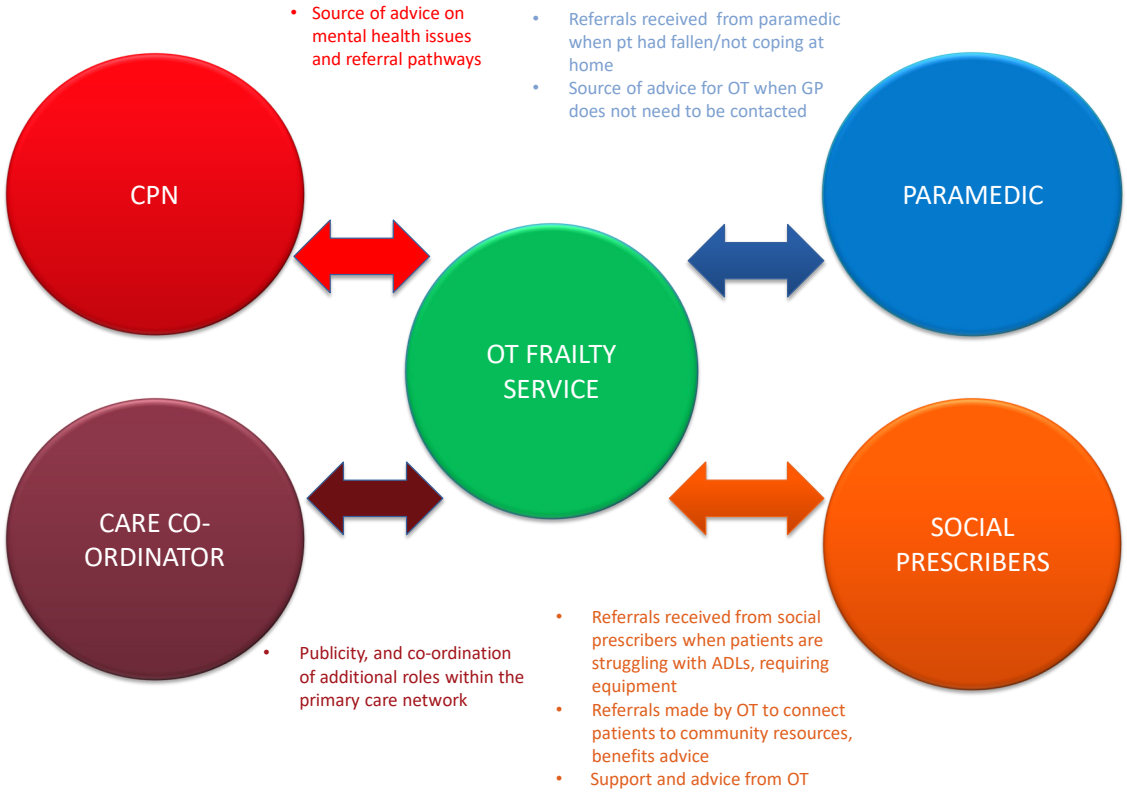
During the initial setting up stage, services were contacted to scope out existing support available to patients with the aim of limiting duplication, promoting integrated working practice and creating a robust network to ensure patients were linked in, and signposted to all available existing services to support their health and wellbeing. (see diagram 3)

Diagram 3 SERVICE NETWORK AND REFERRAL ROUTES

WORKING ALONGSIDE ADDITIONAL ROLE STAFF

Links and working relations were established with the additional role staff in the PCN, illustrated in diagram 4, with monthly meetings taking place. Additional role staff are increasingly referring directly into the Frailty service as the additional role staffing team develops.

Diagram 4 OT WORKING LINKS DEVELOPED WITH ADDITIONAL ROLE STAFF



4. METHOD AND DATA COLLECTION

Once the service was established, a service evaluation was planned using the following methods:

Process measures

A spreadsheet was kept to document the number of referrals including: referral source, patient clinical frailty score, Patient identified goals

Clinical outcome measure:

The Goal Attainment Scale (Rockwood et al 2003) was used with patients to identify person centred, meaningful goals and achievement of the goal

Subjective feedback

Patient and carer satisfaction: Patients and their carers discharged from the OT frailty service in June and July 2021 were asked to complete a patient and carer satisfaction sheet. Patients and their carers were asked to rate their satisfaction of the Frailty service using a Likert scale rating from 0 (very unsatisfied) to 5 (very satisfied) Patients were asked to expand on their experience and give reasons for their scoring.
GP /referrer satisfaction: an anonymous questionnaire distributed to referrers (GPs, Social prescribers, paramedic) using Google forms. The questionnaire included qualitative and quantitative data.

TARGET POPULATION

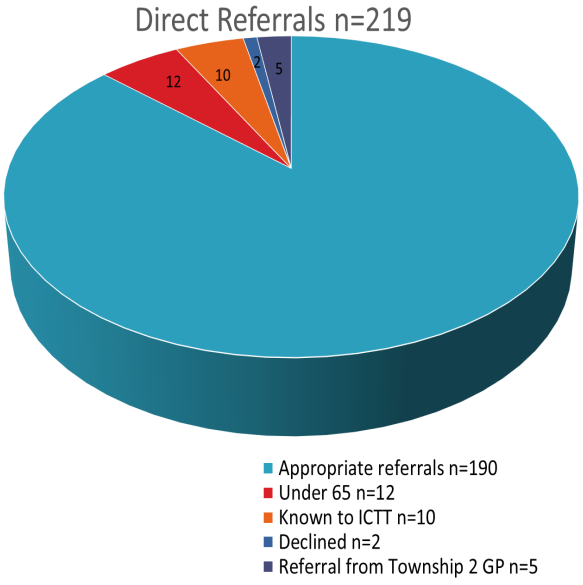
This service development project included patients who met the following criteria, as specified by the initial bid to the CCG:

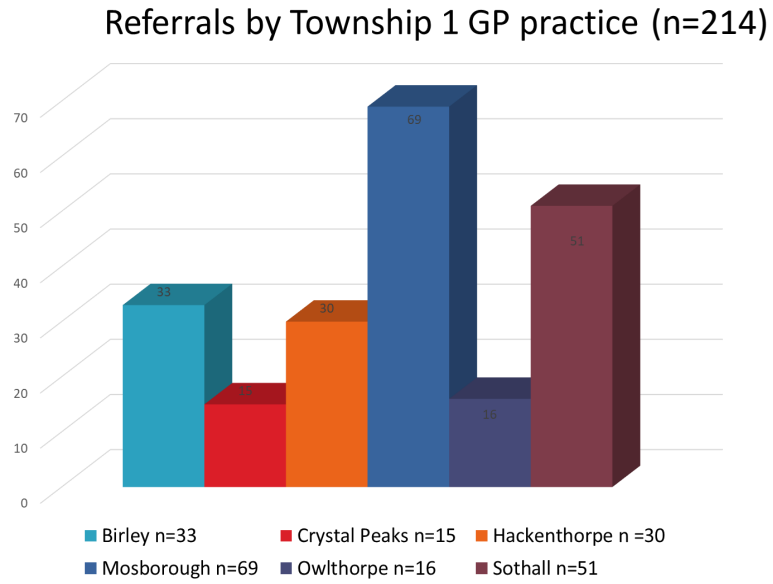
- Over 65
- Housebound and cannot access their GP surgery
- Have a diagnosis of moderate/severe frailty
- Consented to Occupational Therapy involvement

5. SUMMARY OF DIRECT REFERRALS TO OCCUPATIONAL THERAPY SERVICE

A total of **219** direct referrals were received over the 12 month period; **190** referrals met the criteria to access the frailty service. Patients who were referred and did not meet the age referral criteria (n=12) were contacted by phone and signposted on to the appropriate services by the PCN OT in order to address patients' work related support needs or long term condition management needs. 10 patients were known to the Integrated Care Therapy Team (ICTT) and already receiving active therapy.

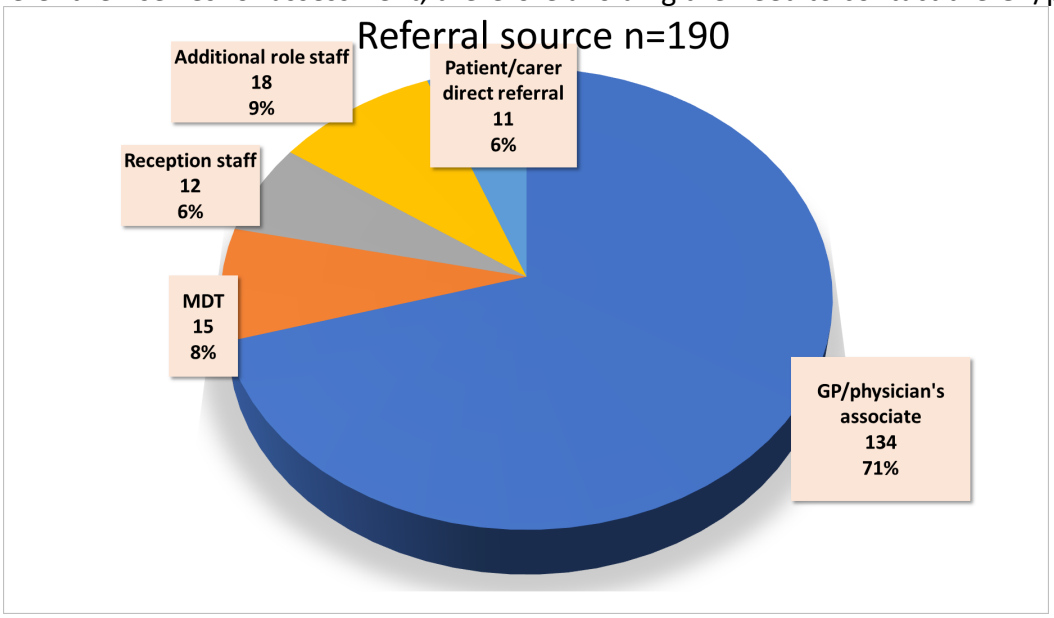
The referral rates have grown steadily over the 12 months, with an average of 21 referrals received per month since January 2021. Referrals were received from all six GP practices in Township 1 PCN; with most referrals coming from Sothall and Mosborough GP practice.





71% of the referrals received into the frailty service were from GPs and physician's Associates. An increasing number of referrals are being received from the additional role staff (9%) , including Social Prescribers (SPs) and the Paramedic, and directly from reception staff (6%).

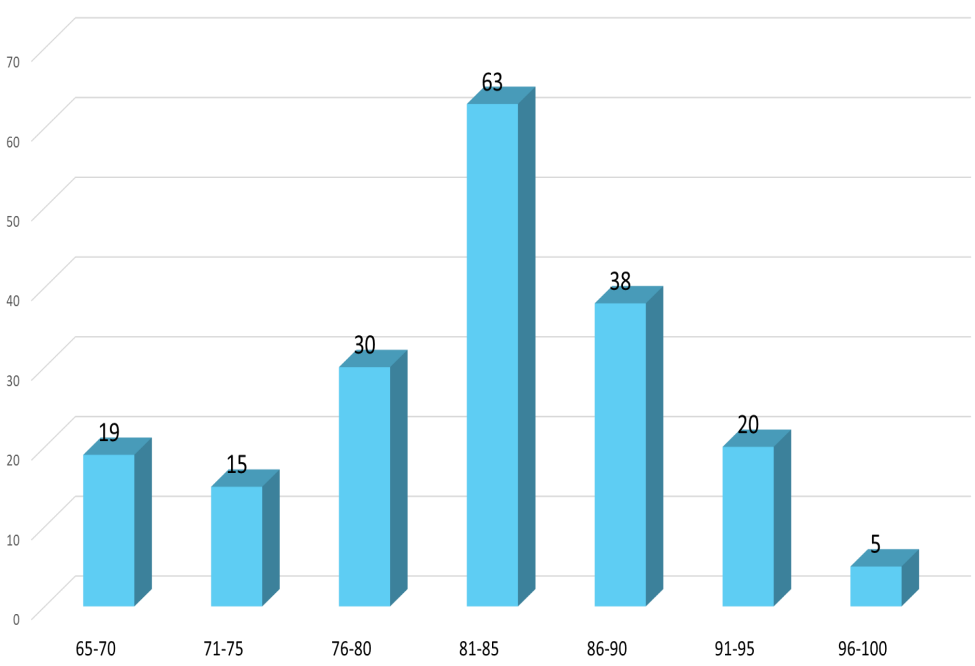
As the service has become more established, patients are making direct contact with the OT to arrange a review and refer themselves for assessment, therefore avoiding the need to contact the GP/practice directly.

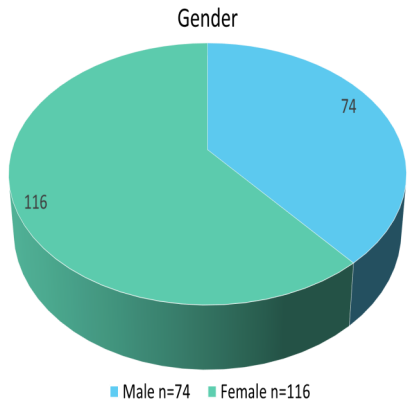


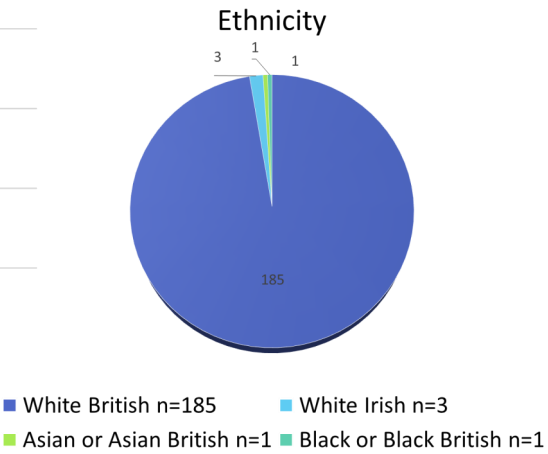
6. SUMMARY OF PATIENT DEMOGRAPHIC INFORMATION

Most patients accessing the service were between the ages of 76 and 90, with more women (n=116) than men (n=74) being referred.

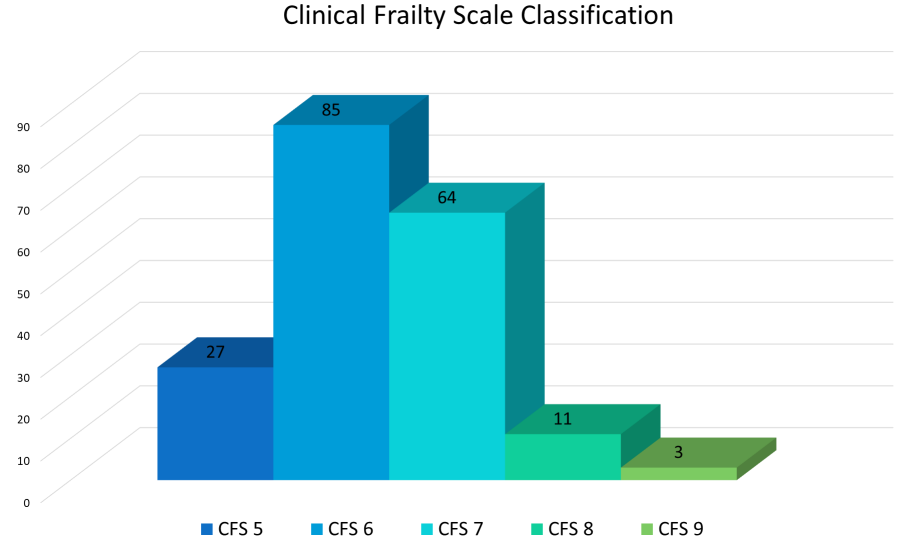
With reference to ethnicity, patients were predominantly classified as White British (97%), being reflective of the general population within the Primary Care Network.







Patients' levels of frailty were classified on initial assessment using the clinical frailty scale (British Geriatrics Society 2018) . Most patients presented as experiencing either moderate frailty (n=85) or severe frailty (n=64), with smaller numbers of patients experiencing mild frailty (n=27), very severe frailty (n=11) or terminal illness (n=3)



Clinical Frailty Scale

CFS5 **Mildy Frail,** more evident slowing, and need help with high order IADLs

CFS6 **Moderately frail,** requiring help with all outside activities, can have problems with the stairs, and may need help with bathing

CFS7 **Severely frail, c**ompletely dependent on personal care

CFS8 **Very severely frail**, completely dependent, approaching end of life

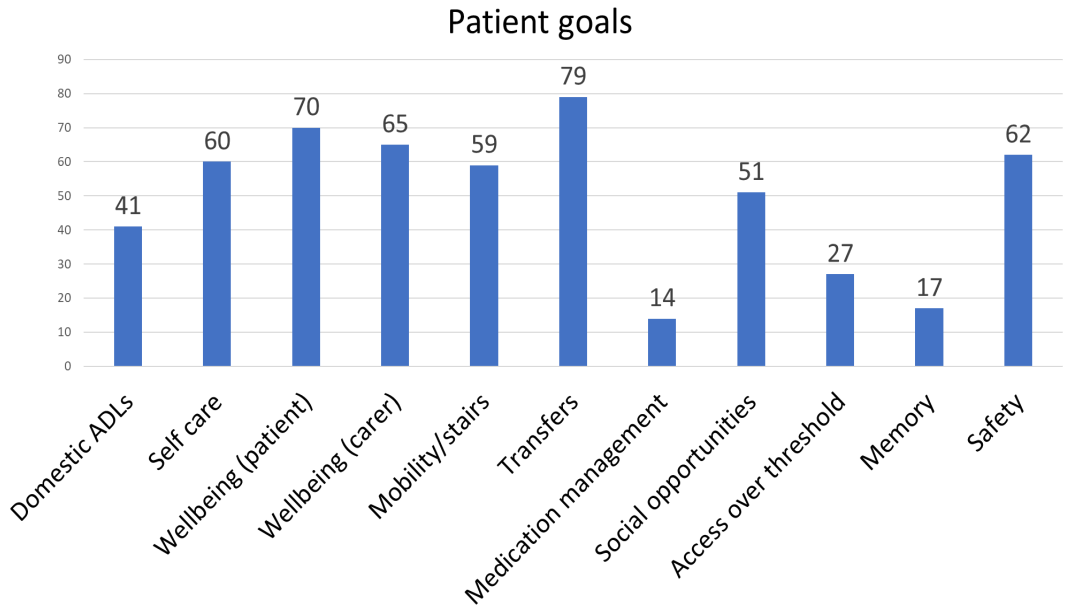
CFS9 **Terminally ill,** approaching end of life with life expectancy of less than 6 months

7. OVERVIEW OF OCCUPATIONAL THERAPY INTERVENTIONS

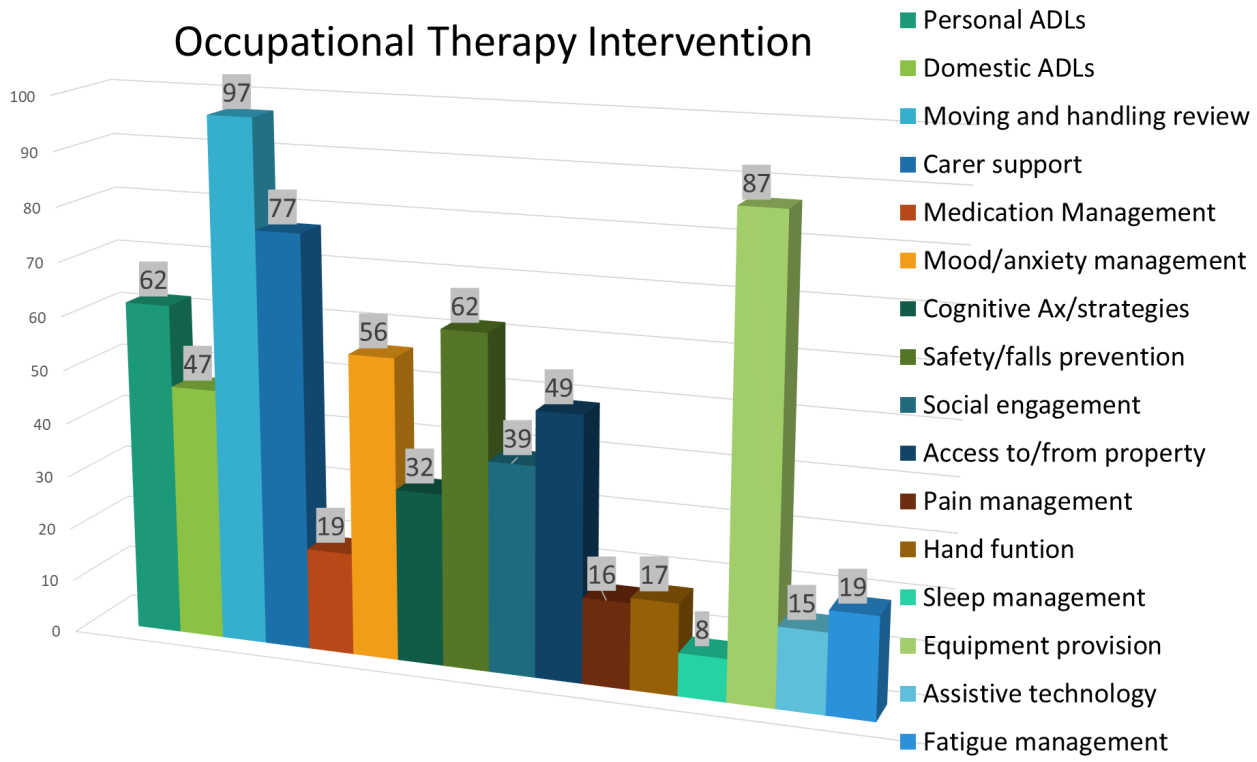
Patients and their carers referred into the service were offered an assessment to identify self management strategies, and practical solutions to issues they face which impact on their overall occupational performance.

Patient goals

Patients explored achieving or maintaining a breadth of occupational goals relating to the areas below. Patients frequently identified more than one goal to help improve the quality of their lives.



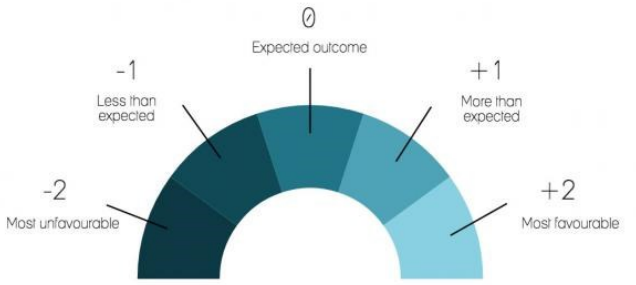
Occupational Therapy interventions were wide-ranging, often working alongside patients' families. The main areas for OT intervention throughout the 12 month period were to support patients in self managing activities of daily living, mobility and transfers, equipment and rail provision and establishing carer support strategies.



8. THERAPEUTIC IMPACT -GOAL ATTAINMENT

A patient centred, as opposed to an impairment based goal outcome measure was chosen, which has been validated to work with the frail older population (Rockwood et al 2003) . Using the Goal Attainment Scale, patients were asked to score if their goal has been achieved.

Patients identified if the goal had been attained, which would be the 'expected outcome' (0) and whether they had achieved more (+1, +2), or less (-1,-2)than they had expected to achieve.

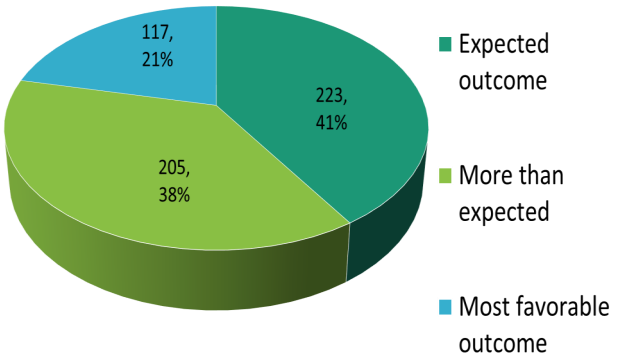


Goal Attainment

All patients seen stated that they had achieved at least one therapeutic goal, with 41% of patient identified goals being met with their expected outcome.

38% of goals were achieved with more than patients had expected, and 21% being most favourable.

It was noted that patients often identified that equipment provision had more of an impact on occupational performance than they had expected.



Examples of patient goal attainment

Mr S lives alone, and over recent years describes becoming increasingly frail (CFS6—moderate frailty). He has a recent diagnosis of dementia, which she and her family were struggling to come to terms with.

Goals: Mr S and her family identified goals to **be safer at home**; **manage the stairs better** following a 'trip' on the stairs, **feel more supported** and **develop strategies to support Mr S's memory**

OT Intervention: An assessment at home was completed, and advice provided on falls prevention, assistive technology e.g. City wide care alarms, and a key safe. An assessment was made for a second stair rail and rails to promote safe transfers in the bathroom. With consent, referrals were made to the Dementia Advice Service and the Carer's Centre. Compensatory memory strategies were explored following a formal assessment (ACE111), for example using reminder systems for appointments and medication.

The OT visited twice at home, and phoned the patient/family 3 times for monitoring/follow up.

Outcome: Goals achieved. Mr S and his family scored their overall goal attainment as 1, better than expected

Mrs P lives with her son in law, following the recent loss of her daughter.

Goals: On initial assessment, Mrs P identified goals o **access her shower** and was requesting an adaptation/wet room. She also wanted to be able to **make meals** and **do the ironing** but described difficulties due to reduced standing tolerance which prohibited her from participating in activities in the kitchen, relying on her son in law for meals etc. Mrs P further identified a goal to **access the garden,** which was difficult due to 3 steps leading from her back door. Mrs P described feeling isolated and low in mood following her family bereavement as was keen to access **bereavement support.**

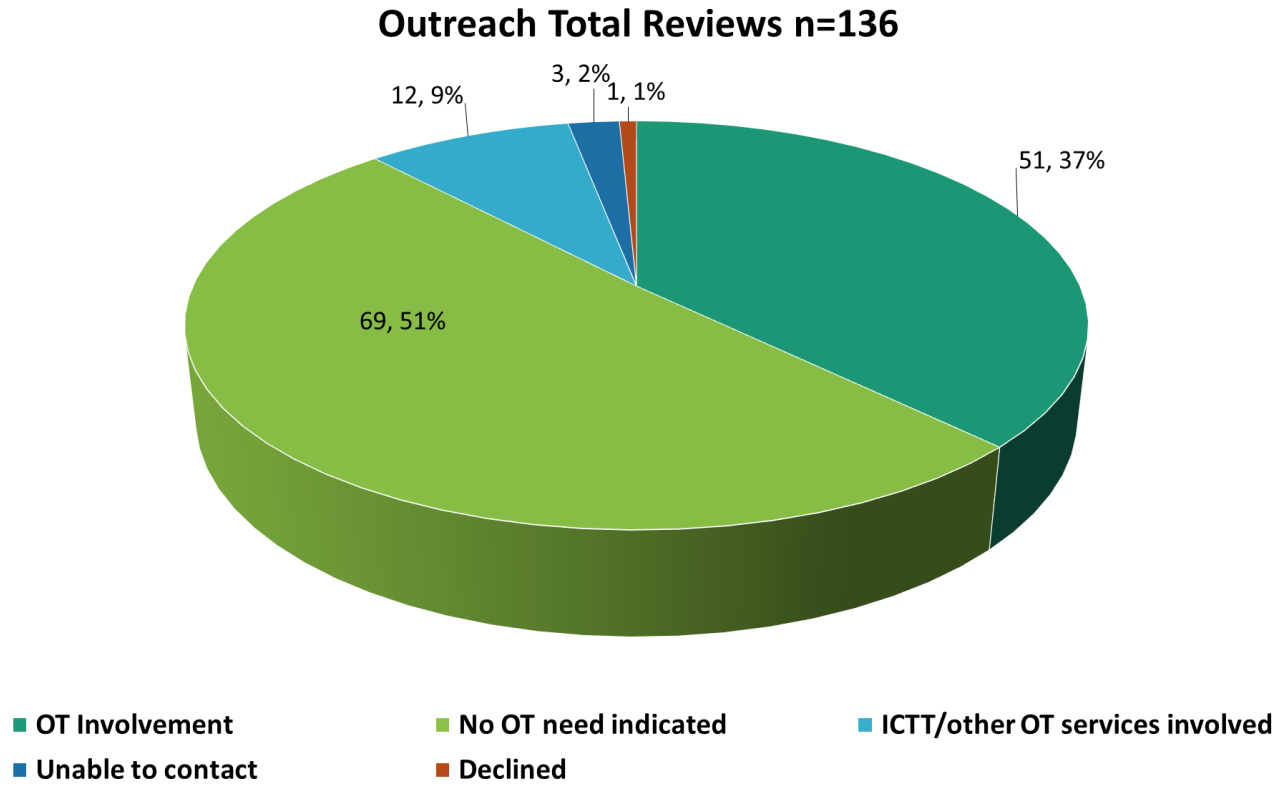
OT intervention: Mrs P was assessed at home, and with support from OT, practised using a shower board and grab rail in her bath to shower. Mrs P trialled a perching stool to sit on when making meals/ironing; and was assessed for rails to provide access to the garden. Mrs P was provided with support around her recent loss, and signposted to bereavement services.

The OT visited three times at home, and phoned the patient three times for monitoring/follow up

Outcome: Goals achieved. Mrs P scored her overall goal attainment as 2, most favourable

9. SUMMARY OF NON-REFERRALS: PATIENT OUTREACH REVIEWS

From 1st October 2020 to September 30th 2021, outreach telephone reviews were completed with **136** patients, identified by taking patient lists off Systmone electronic computer system who were coded as 'housebound' and living with 'moderate' or 'severe' frailty. Patients were contacted by phone and offered a conversation which holistically explored areas such as how they were managing at home with activities of daily living, mobility and transfers; their mood and support network, access to social opportunities, nutritional levels, risks and any concerns patients could identify.



37% of patients had active OT involvement following on from the initial conversation. Interventions centred on:

- Signposting to other services, for example the social prescribers in order to access befriending services, benefits advice, and community activities
- Falls prevention, goals to improve mobility and transfers, equipment and rail provision and the development of self management strategies to support occupational performance.

Patients who did not require active OT input frequently expressed being grateful for the review and opportunity to talk about how they are currently coping with day to day activities, and awareness of the service should they require OT involvement in future. Patients often commented on the value of the conversation about what mattered to them in the context of the COVID pandemic when social isolation, and lack of interaction was prevalent for this cohort of patients.

5 patients who were initially contacted through the outreach service have since self referred directly into the service.

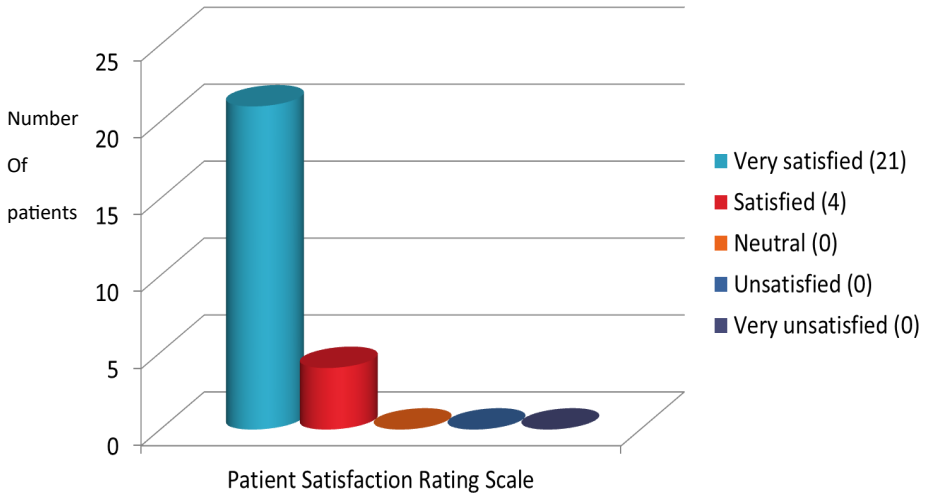
10. PATIENT AND CARER FEEDBACK

All patients discharged during June and July 2021 were asked to complete a brief patient and carer satisfaction questionnaire and provide feedback on their experience of the service. The questionnaire asked patients to rate their satisfaction level of the service that patient's and their carers had received. They were asked to elaborate in the score with additional information describing the reasons for the score and further information.

PATIENT SATISFACTION RATING SCALE

Feedback was received from 25 patients accessing the service.

Out of the 25 responses, 21 rated their satisfaction levels as 'very satisfied', and 4 rated the level as 'satisfied'.



PATIENT FEEDBACK—COMMENTS ON THE EXPERIENCE OF THE SERVICE

Taken together, the comments made by patients and their carers broadly fell into three overarching themes, where satisfaction related to the **accessibility** of the service**,** the overall **approach** of the occupational therapist**,** and **the therapeutic impact** of the service on their wellbeing, quality of life and independence levels.

ACCESSIBILITY

Patients were frequently grateful for how quickly they were seen by the OT, and also the **speed** at which actions were completed, particularly when accessing equipment required. This was noticeable with patients who had not seen an OT before.

'I'm pleased with the way my doctor referred to (the OT) and the speed of the service (patient)

'We are delighted with the speed, and how quickly the wheelchair, the equipment came' (patient's wife)

Significantly, patients and their carers highly valued accessing the Occupational Service through their GP as their GP was a trusted referral source, being **familiar** to them and seeing the OT face to face at home. Patients appreciated that the Occupational Therapist was locally available, 'joined up' with the GP service and easier to access. They identified how this connection helped to overcome potential barriers to accessing The Occupational therapy service, such as travelling to services and anxiety, which can impact on access to service involvement.

'Because I've got mental health problems, knowing (the OT) came from the surgery really helps. Its nice to have that 'all in one' thing rather than someone coming from somewhere else, that (the GP) recommended' (patient)

'(The OT) put me at ease, its easier knowing she came from the surgery '(Patient)

Its very good having someone I know on our doorstep we can get help and advice from (patients partner)

Patients and carers appreciated having future OT input via their GP surgery, if required. They placed value on the **continuity** of the service in GP practice; and that the OT was now familiar to them.

'Its comforting to know the service is there' (patient)

'I know (The OT) is there if I we need anything, if anything changes' (patient's daughter)

APPROACH

Patients identified the **support** and reassurance received from the OT as positively impacting on how they coped with their overall occupational performance. This was particularly relevant given the impact of COVID restrictions on patients' social networks and social isolation. Patients appreciated having opportunity to talk openly about their current situation, personal stressors and functional difficulties.

'I've never had anyone ask if I need help, what's hard for me - its brilliant. I'm finding everything a bit much, thanks for being there' (Patient)

'You can talk to the OT, she listens. I did find it useful, it really helped being reassured' (patient)

Patients further valued the OT's general advice, problem solving and knowledge of other services that patients could **connect** with to provide support:

'The OT knows the 'ins and outs' of what's available, its been smashing – very helpful and knowledgeable' (patient)

'I'm pleased with how the OT has been – I know if anything was possible, she would do it' (patient)

THERAPEUTIC IMPACT

A key part of the feedback received highlighted how Occupational Therapy involvement impacted on patients' ability to function in their own homes and remain as independent as possible. This particularly related to the role of equipment and self management strategies on patients **achieving functional goals:**

'I can get around my flat now, its much easier as the furniture, my walker isn't in the way. (patient)

I'm so pleased someone has looked at my memory. I think its very useful to think about what can help (patient)

'Its much easier, I can get out of the bath (patient)

Some patients recognised the impact that OT had on their **confidence** levels, as being instrumental in the process of meeting their goals:

'Its helped with my self-confidence, I've been out with friends and I can use the trolley in the kitchen. The rails lovely' . (patient)

'its been a massive help, it gives me confidence that I won't fall' (patient)

Finally, the OT role in **prevention** within this context was further highlighted in relation to preventing falls by some patients and their carers:

> It's a fantastic idea because it prevents falls before it happens, like with my father. Coming round, its less stressful and everything happened quickly' (patient's daughter)

Summary diagram 5 showing key satisfaction themes and points to emerge from patient and carer feedback

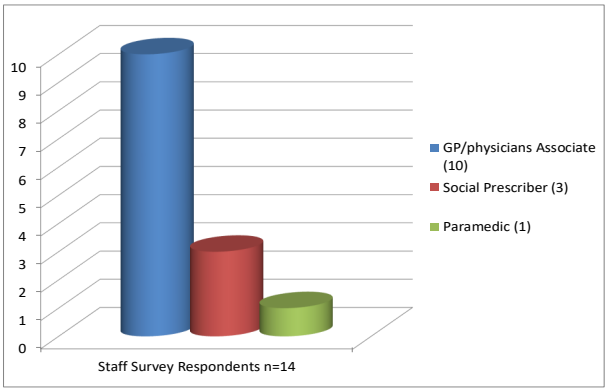
In summary, overall satisfaction levels with the OT Frailty service were high. Patients and their carers valued the speed of being seen by the OT frailty service, and that they were referred directly via the a health professional/ the GP surgery, who was familiar to them. The 'open door' referral system and familiarity of the OT was appreciated, should the service be required again in future.

Given the context of the Covid-19 pandemic, patients particularly appreciated accessing support, seeing a professional face to face, and opportunity to be connected into other services.

Patients identified achieving their goals and improved confidence levels as a result of Occupational Therapy input as having a positive impact on their lived experience.

11. GP PRACTICE STAFF FEEDBACK

As part of the evaluation, an anonymous electronic survey was sent out via e mail at the beginning of August 2021 to surgery staff employed by Township 1 PCN, who could refer into the service. This survey covered four areas relating to the overall **use of the OT frailty service, Occupational Therapy Clinical effectiveness, service efficiency and impact,** and the **general overview of the service**.

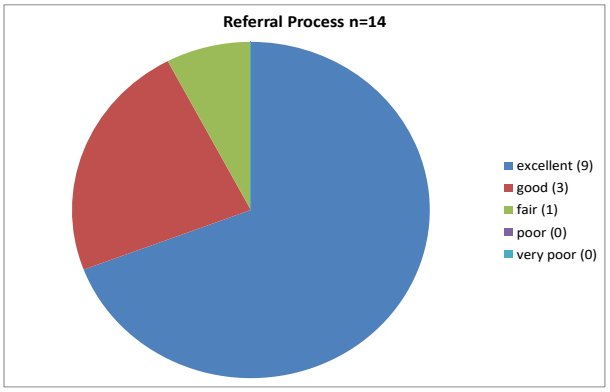


14 staff members responded to the questionnaire, including GP/physicians Associates (10), Social prescribers (3) and the network paramedic (1). 13 of the staff responding to the survey had used the service, with one GP reporting he had not used the service.

USE OF THE FRAILTY SERVICE

ACCESSIBILITY

Staff were asked about the referral process and the use of the Township 1 booking ledger to directly refer for an OT appointment. Of the 13 staff members who had used the service, 9 identified the process as 'excellent', 3 as 'good' and one as 'fair'. Staff commented on the ease of accessing the service through systmone, the efficiency of the process, and accessibility for additional role staff who would not normally have access to Occupational therapy.



'It is really accessible especially when you don't have time to complete a lengthy referral form' (SP)

'It has provided a quicker, higher quality link to OT input' (GP)

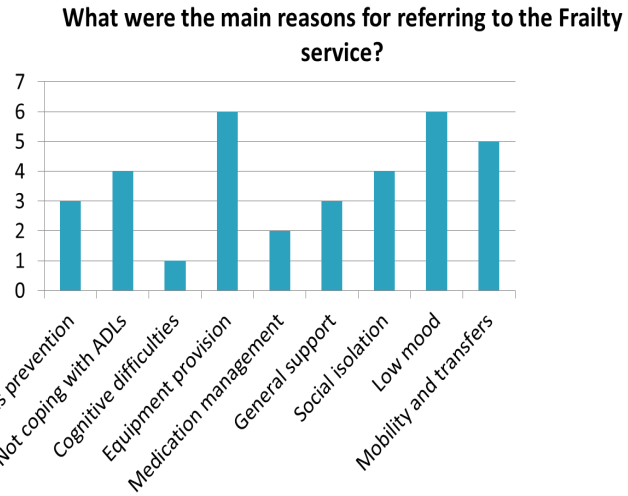
'Having direct access to someone (OT) in primary care—especially because referring into some professionals can be particularly hard if you are not a GP or nurse (SP)

With regard to information about the service, 13 staff members felt they had an enough information to make appropriate referrals. The GP who had not used the service highlighted the need for ongoing reinforcement of the role so staff remember that the service is there. Also more face-to-face contact with the Occupational Therapist in surgeries was suggested as being beneficial in reinforcing the OT role due to its novel nature and need to understand the concept of Occupational Therapy in general practice.

REASONS FOR REFERRALS

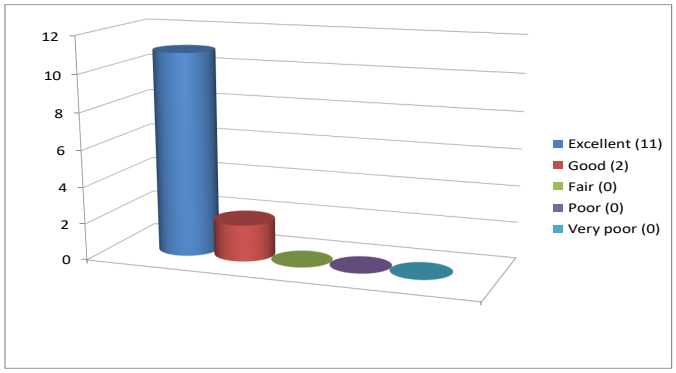
Staff referred into the Frailty service for a variety of reasons, with equipment provision, concerns around low mood/patients not coping, and reas-sessment of mobility and transfers being the most common reason.

Three GPs requested further information about the scope of OT input, with the aim of developing their understanding of the role so they could make full use of the service.



QUALITY OF THE FRAILTY SERVICE

Staff who had used the frailty service were asked about the quality of service delivery. 11 staff members described the service as 'excellent', and 2 as 'good'. Staff particularly appreciated the overall approach and support provided to the more complex needs of frail older patients.



'able to provide a service to some very complex and frail patients very efficiently and comprehensively (GP)

'caring, compassionate and a very comprehensive service to the patient' (GP)

OCCUPATIONAL THERAPY CLINICAL EFFECTIVENESS

PATIENT AND CARER FEEDBACK

Township 1 PCN staff were asked specifically about feedback received from patients and their carers in order to provide a comment on how effective the OT intervention had been and how it had impacted on patient care. 11 staff members had received feedback, describing that patients and carers were grateful for the support, finding the OT input helpful, appreciating access to equipment and having their goals addressed quickly.

'All feedback very positive, quick to be seen and thorough assessment' (GP)

'They (patients and carers) have been complimentary of the care and attention they received' (GP)

'The OT really helped their mum with an assessment and onward referral and made them feel more hopeful' (SP)

THE OCCUPATIONAL THERAPY APPROACH

The holistic, person centred and flexible approach used within the Occupational Therapy role was identified as making a contribution to the PCN, with the assessment process described as thorough. The potential breadth, and scope of interventions offer by the OT as commented on favourably, with one GP commenting that they had not been aware of the full scope of interventions available.

(The OT) is very supportive and reviews patients holistically which often identifies needs that perhaps wouldn't have been discussed by other professionals (Paramedic)

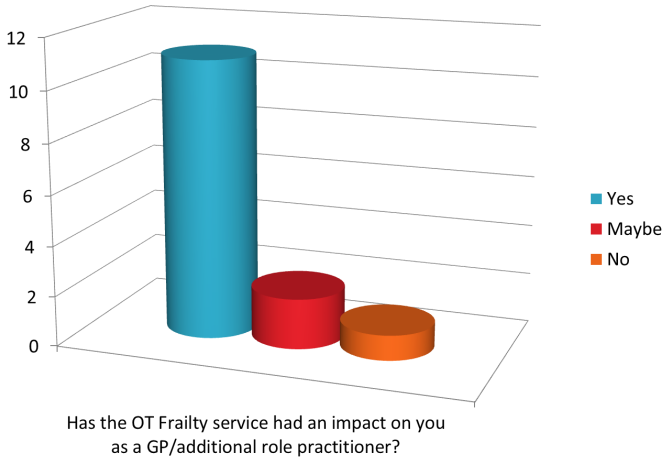
The extra support (the OT) is able to give patients. They are able to run a thorough check to make sure they (patients) have everything they need and I think this is really important' (SP)

(The OT) makes people feel listened to, and goes out of their way to help (GP)

'I can see from my referrals that my patients have been managed in a very holistic way' (GP)

SERVICE EFFICIENCY AND IMPACT

11 of the 14 staff members using the service identified that the new role had impacted on their work, with two GPs saying it maybe had an impact. The OT service had not impacted in the GP who had not referred to the service.



Has the OT Frailty service had an impact on you as a GP/additional role practitioner?

A significant part of this impact identified by GPs specifically related to signposting on to other organisations on their behalf:

> I feel that this [at least as much as anything else introduced in the PCN] has saved GP time, paperwork and worry, as well as enhancing patient experience (GP)

> (The OT) has been flexible in dealing between all the various specialties, agencies and remits, has been timely, efficient, generally effective (GP)

> (The OT) can complete or signpost to appropriate services for individuals - aware of options available more easily than GP having to look up / refer to all services. works as a team with some of these services more

IMPACT OF THE OCCUPATIONAL THERAPIST ON ADDITIONAL ROLE STAFF

All additional role staff valued the contribution that the Occupational Therapist had in the emerging team in terms of support, collaborative working and contributing the Occupational Therapy perspective/ knowledge base to patient care:

> (The OT) has positively impacted our role, not just for referring people but for advice and input at meetings across the townships (SP)

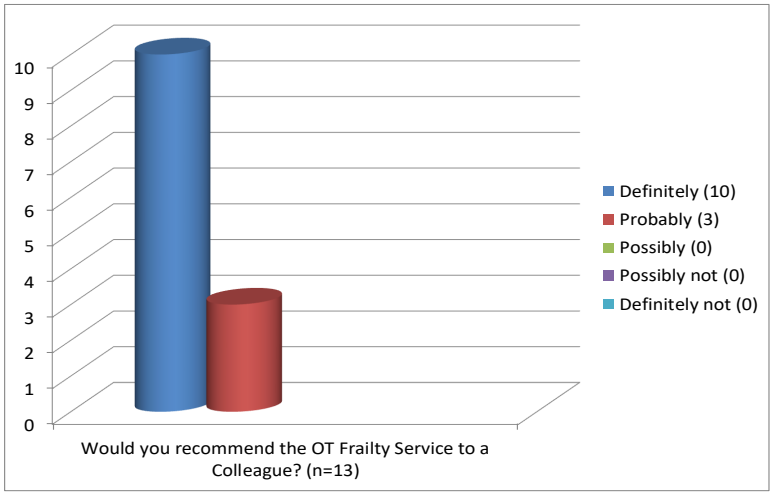
> It is nice to work alongside the OT as we can bounce off each other with cases where we are both supporting a patient (Paramedic)

GENERAL OVERVIEW OF THE SERVICE AND SERVICE DEVELOPMENT

Finally, staff were asked if they would recommend having access to the Occupational Therapy Frailty service to colleagues, if the service could be improved and any further comments.

10 out of 13 staff members said they would recommend the service to colleagues, with three probably recommending it.

GPs who would recommend the service were keen for the service to remain as an additional role in the PCN.



'their strength is their flexibility' (GP)

'Found very useful, please don't discontinue the service' (GP)

Some of the GPs recognised that as a relatively new service, it would be useful to have more experience of the service before stating how it could be developed. One GP requested more information about the full scope of OT in PCNs before commenting on how the service could be improved, while another was mindful of OT capacity if widening the remit for OT involvement with patients.

Finally it was recommended by GPs and additional role staff that the age limit was extended to include patients under 65 with longer term conditions and/or experiencing return to work issues, with the option suggested of employing a further OT to accommodate an expansion of the role.

SUMMARY OF GP PRACTICE STAFF FEEDBACK

The overall response to the OT Frailty service within Township 1 PCN was positive. Staff generally found the referral processes efficient and user friendly. Reasons for referral covered a breadth of OT involvement, with the overall quality of service delivery generally rated highly.

Feedback to GPs and additional staff concurs with the patient feedback, that patients and their carers appreciate the speed of being seen and valued the input from the Occupational Therapist. The nature of the Occupational therapy approach as holistic and thorough was also valued by staff within the PCN, and the breadth of knowledge relating to other services available to support patients.

The need for more understanding of the OT remit and scope of practice, and greater visibility within surgeries was highlighted. The expansion of the OT role to include patients under the age of 65 was also suggested.

12. CONCLUSION

This evaluation demonstrates that the frailty model developed is fit for practice. The OT Frailty service is embedding itself in the Township 1 PCN, having a positive impact for staff working in the PCN and patients receiving the service. The role has demonstrated added value to GP practice on a clinical, and service level. The OT role contributes to the Additional role staffing team; a role which can be developed to include future supervision responsibilities for staff.

Since the start of the Frailty project on 1st October 2020, 190 patients have received Occupational Therapy input following direct referrals into the service, and 136 patients have been proactively reviewed as part of the outreach, anticipatory care role. Referrals were received from all GP practices; most coming from GPs/Physicians' Associates and emerging re-referrals from patients. Significantly, patients, additional role staff, and reception staff are starting to refer directly into the service, therefore limiting the need for direct GP input in the referral process.

Data on the OT interventions and patient goals illustrate the diversity of OT input with patients to support occupational performance, wellbeing and quality of life, working alongside additional role staff and established services to meet the needs of the frail older population in Township 1 PCN. Goal attainment outcome measures demonstrate a high level of clinical effectiveness and impact in the delivery of the frailty service.

Subjective feedback from Patients and referrers indicates that the speed of OT input, and accessibility of the service were highly valued. Patients appreciated having access to an OT as part of their primary care service to support their independence and confidence to remain at home. Referrers recognised the holistic contribution of OT in supporting the complexities faced by older patients living with frailty.

13. RECOMMENDATIONS

As a result of this service evaluation and the first year of the OT frailty service in Township 1 PCN, the following recommendations are made to further develop the frailty service, and Occupational Therapy role within the PCN:

⇒ Continue to provide a clinically effective and efficient OT Frailty service for older adults in Township 1 PCN funded under the role re-imbursement scheme, building on the scope and magnitude of the initial pilot project

⇒ Further publicise the role of Occupational Therapy with staff in GP practices, including more visibility in GP surgeries where possible

⇒ Further develop the links and team working with additional role staff as they come into the PCN to maximise the personalised care approach within the PCN. This includes a supervisory role with additional role staff, for example social prescribers

⇒ Develop systems to support the 'first contact' role (direct referrals from patients, receptionists and additional role staff) to maximise the impact on GP time, in line with the impending First Contact Occupational Therapy Roadmap for Primary Care

⇒ Continue to collect data with the aim of further researching and evidencing the impact/added value of Occupational Therapy in primary care

⇒ Consider the longer term resources required to develop the OT role to include patients experiencing mild frailty, patients under 65, and patients requiring support with their return to work needs

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