Enquiry into Occupational Therapy Services in Kingston upon Hull

Scrutiny Report No 17

August 2003
Chair’s Foreword

This report is the culmination of a long-running enquiry which was undertaken in response to Member concerns about long waiting lists for assessment and treatment and duplication of effort between the Local Authority and the Health Service.

The Commission has received evidence from a wide range of sources including Occupational Therapists themselves, and we are very grateful for their helpful contributions of both their time and experience. The Commission’s conclusions were based on a strong belief that integration across the authority and health sector would ultimately lead to a better service for clients.

I commend the report to the Council’s Cabinet, the PCTs, Community Trust and the Hospitals Trust as a way forward which I hope you will accept.

Councillor Peter Clark
Chair of the Health and Social Well-being Overview and Scrutiny Commission
SUMMARY OF RECOMMENDATIONS

The Panel's detailed conclusions and recommendations are set out in the report, but for ease of reference, the recommendations are set out here.

Based on the evidence heard the Commission concluded that it would be necessary and useful to set a number of short and long term recommendations.

9.1 Short-term Recommendations

The Commission therefore agreed that the following short-term recommendations should be implemented by April 2004.

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9.1.1 That all of the Health Trusts that operate within the City ensure that they work jointly with the Social Services Department on the development of services.

9.1.2 That, at a minimum, a small, preferably central, needs assessment and demonstration centre be set up where clients can collect equipment.

9.1.3 That a catalogue of common equipment should be developed for use across all agencies.

9.1.4 That a specific member of administrative staff should have responsibility for requests for equipment.

9.1.5 That, subject to a feasibility study to establish if there is sufficient administrative time, all Occupational Therapists and Occupational Therapy Assistants within the Social Services Department should have access to voice recording equipment (Dictaphones) to enable dictation of case notes.

9.1.6 That, due to the duplication of effort, the use of locum/bought in Occupational Therapists be avoided where possible.

9.1.7 That staff development and training should be implemented. A reciprocal rotation system that is in place in relation to Hull Royal Infirmary should be broadened to encompass the Intermediate Care Team. Staff should be encouraged to take on rotations as a way of developing their skills.

9.1.8 That career development for Occupational Therapy Assistants who wish to undertake appropriate training and qualifications should be promoted.

9.1.9 That Occupational Therapy as a career option should be actively promoted. This should be done through stands at careers events and road-shows. Information should also be provided to schools and colleges etc. to encourage young people to think about Occupational Therapy as a career option.
9.1.10 That detailed consideration be given to dedicated advice officers being based within the Occupational Therapy Team.

9.1.11 That the Committee supports the Social Services Department Occupational Therapy service in its bid for premises at Mount Pleasant.

9.1.12 That the Council nominates a ‘champion’ to represent the Occupational Therapy service.

### 9.2 Long-term Recommendations

The Commission agreed that the following long-term recommendations should be implemented by April 2007 with the aim of providing a seamless service for clients through a multi-agency team that can effectively follow a client through every step in the rehabilitation process and also provide clients with assistance in relation to equipment, aids and adaptations. Where possible a client should have an Occupational Therapy key-worker who is able to remain with the client throughout involvement.

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9.2.1 That Social Services works with other agencies involved to ensure that the processes, systems, finance and organisational (including administration) arrangements are effective and in place in order to facilitate the long term plans.

9.2.2 That a comprehensive multi-agency integrated occupation therapy team be established which should incorporate both intermediate and long term rehabilitation services and the promotion of mobility and independence through provision of aids and adaptations. The integrated team should include both NHS agencies and Social Services.

9.2.3 That the implementation of a Key Competency Scheme aimed at encouraging staff to develop a wide variety of expertise should be considered in detail.
ENQUIRY INTO OCCUPATIONAL THERAPY SERVICES

Report of the Health and Social Well-Being Overview and Scrutiny Commission

1 Introduction

1.1 The Health and Social Well-being Overview and Scrutiny Commission began this enquiry in November 2002 in response to reports of difficulties in the provision of occupational therapy services within the area. These difficulties have come in the form of delays in the referral – assessment – implementation process and a duplication of assessments and effort between the health and local authority. In addition to responding to the difficulties identified it was felt that the Commission would be able to take a pro active role in light of the many new frameworks, strategies and guidance relating to services for older people.

1.2 The members who took part in this enquiry were: Councillors Burton, Clark (Chair), Ellis, Glew, Godden, Hancock, Hewitt, Obridge (Deputy Chair), Page, Wastling, White and (Mrs) K Woods.

2 Aim of the Enquiry

2.1 To investigate the delivery of occupational therapy services provided by Kingston upon Hull City Council Social Services Department and the local NHS Trusts in order to maximise co-operation and co-ordination, with a view to ensuring that services are accessible and easily available to those who need them within reasonable timescales.

3 Objectives of the Enquiry

3.1 To identify the organisations involved in providing occupational and rehabilitation services within the city.

3.2 To establish levels and types of service provision by the organisations involved.

3.3 To establish who has overall responsibility for therapy services in provider organisations.

3.4 To examine current inter and intra-agency and joint partnership working arrangements.

3.5 To examine procedures for assessing needs.

3.6 To consider financial issues and implications:

   (i) funding of services and equipment
   (ii) means testing
   (iii) grants and subsidies
   (iv) budgetary information
3.7 To examine how the services are marketed:

(i) How/where/how often are services advertised?
(ii) Is any research undertaken on effectiveness?
(iii) Is there a cost benefit in promoting the service?

4 Range of evidence – verbal and written

4.1 During the course of the enquiry both verbal and written information were received from a range of stakeholders and other interested parties.

4.2 The Commission saw the following in order to gather information regarding the local context:

- Mr Jan Didrichsen - Director of Social Services
- Mr Alec Pearson - Assistant Director of Social Services (Adults)
- Mr Mark Morrison - Director of Performance for the Hull and East Yorkshire Hospitals NHS Trust
- Mr Simon Hallion - Hull and East Yorkshire Hospitals NHS Trust

4.3 The Commission saw the following in order to gather information regarding the national context and comparisons of how other authorities ensure best practice:

- Ms Claire Beighton - College of Occupational Therapy
- Ms Laurie Rose - Darlington Health Trust

4.4 In addition further information was received from the following sources:

- Mr Douglas Caldwell - Director of Health Improvement, East Hull Primary Care Trust
- Mr Ritchard Ledgerd - College of Occupational Therapists (Students Officer)
- Mr Stephen Greep - Chief Executive, Hull and East Yorkshire Hospitals NHS Trust
- Ms Eileen Henderson - Head of Therapies, Hull and East Yorkshire Hospitals NHS Trust
- Ms Bernice Nwangkwo - Head of Occupational Therapy Services, Hull and East Riding Community Health Trust
- Ms Claire Brown - District Adults Manager, Social Services Department Kingston upon Hull City Council
• Ms Johanne Evans - Head of Therapies, Hull and East Riding Community Health Trust
• Ms Linda Glasby - Chief Executive, Hull and East Riding Community Health Trust
• North Tyneside Community Disability Service, Tyne and Wear
• London Borough of Camden Council Disability Services

4.5 • Site visits were undertaken with:
  • Hull Intermediate Care Team
  • Hull Royal Infirmary
  • Hull Social Services – Physical Disability Resource Team

5 Background

5.1 The National Context - Frameworks, Guidance and Strategy

5.1.1 The British Association of Occupational Therapists and College of Occupational Therapy have laid down the definition of occupational therapy as being “…the treatment of people with physical and psychiatric illness or disability through specific selected occupation for the purpose of enabling individuals to reach their maximum level of function and independence in all aspects of life…” (British Association of Occupational Therapists/College of Occupational Therapy)

5.1.2 Occupational therapy services are provided by both Primary and Secondary Care services within the NHS (PCTs and Hospital and Community Health Trusts), by the Local Authority Social Services Departments, and also by private practitioners. However the provision of services varies between authorities, some deciding to adopt a lead or joint commissioning arrangement whereby all services are provided by one agency, or others opting for integrated service provision working on a multi-disciplinary basis.

5.1.3 The NHS Plan (July, 2000) brings the NHS and local Social Services together with new agreements to pool resources. Public consultation for the plan showed that the public wanted to see:

(i) more and better paid staff using new ways of working
(ii) reduced waiting times and high quality care centred on patients
(iii) improvements in local hospitals and surgeries

5.1.4 The plan sets out how Social Services and the NHS will come together with new agreements to pool resources and outlines the voluntary creation of new care trusts (nominated PCTs or Health Trusts) to commission health and social care within a single organisation.
5.1.5 The new flexibilities, which are being brought in as part of the Health Act (1999, s. 31), and the voluntary care trusts (Health and Social Care Act 2001) have major implications for the way in which agencies are able to deliver occupational therapy services.

5.1.6 The National Service Framework for Older People outlines that the planning and delivery of care should be person-centred and should involve agencies working together in the best interests of the client. Agencies should achieve this by sharing information and effective partnership working not only between themselves but also with the client and their carer(s) who should, where practicable, be involved in the decision making processes about their own care. In addition, services must be geared not only to regaining independence but encouraging clients to realise their full potential.

5.1.7 The College of Occupational Therapists has published a report titled “From Interface to Integration” (College of Occupational Therapy, 2002) which proposes a strategy for modernising occupational therapy services within local health and social care agencies.

5.1.8 The report recognises that the current structure and provision of services means that resources are often tied to specific departments; that there is little or no strategic direction given to community health; that the emphasis on ‘discharge facilitation’ particularly within the NHS is increasing pressure on staff to produce quantity rather than quality; that within Local Authorities there is too much emphasis on legislative function (on providing aids and adaptations); that service delivery is driven by volume and waiting lists, and that staff expertise in the role of counselling clients, providing advice on living with disability and using therapy skills to aid rehabilitation are not sufficiently recognised or utilised.

5.1.9 The report recommends an integrated approach to service provision, whereby communication methods are enhanced and the service-users’ needs are met through a continuum of care.

5.2 The National Context - Training, Recruitment and Retention

5.2.1 There is, and has been for some time, a shortage of trained and qualified Occupational Therapists across the country, in both Health and Local Authorities. The vacancy rate within the NHS in England was 4.9% (March, 2002).

5.2.2 The difficulties encountered in recruiting and retaining qualified and experienced Occupational Therapists are exacerbated by shortages of Occupational Therapists entering and completing post-qualifying and professional training. The number of University and Colleges Admissions Service (UCAS) applications for places on occupational therapy courses has been in steady decline from over 12,000 applications in 1997/8 to under 8,000 in 2001/2 (Joint Validation Committee, July 2002). This is set against a context where overall student numbers have increased from 1,600,000 to 1,800,000. There were 122 unfilled places on courses in 2001/2.

5.2.3 There is a disparity between the nature of occupational therapy work in Social Services and the NHS. Social Services staff tend to have more autonomy than NHS staff, which is potentially the cause of a lack of coherence in the provision of occupational therapy services, but also means that Social Services Departments
have less scope to recruit newly qualified staff due to their inexperience and need for supervision.

5.3 The Local Context – Frameworks, Guidance and Strategy

5.3.1 At present occupational therapy services are provided by a number of agencies and projects within the city and across the Local Authority borders into the East Riding.

5.3.2 The Social Services Department, as well as providing an Occupational Therapy Team, work with the Housing Department, Private Housing Renewals (Disabled Facilities Grants) and the Council House Adaptations Team, with regard to providing and installing aids and adaptations in properties of all tenures. In addition, the Social Services Department also works with the Hull and East Riding Community Health Trust in the Hull Integrated Intermediate Care Service and also with the Community Health Trust and the East Riding of Yorkshire Council on the Joint Equipment Service.

5.3.3 The Primary Care Trusts (Eastern and West Hull) commission occupational therapy services from the Hull and East Riding Community Health Trust. Services are also provided by the Hull and East Yorkshire Hospitals NHS Trust. More details of the services provided are included at Section 6.

5.3.4 Arrangements are being put into place to modernise and integrate the services provided by the agencies within the city. The details of this are contained within the Strategic Action Plan for Older People, produced in response to the Best Value Review of Social Inclusion and Older People. This plan is yet to be endorsed by the Local Strategic Partnership (LSP). The plan’s vision is to “establish integrated services that satisfy the criteria of Best Value to enable older people to remain in the community and live independently” (Strategic Action Plan – Social Inclusion and Older People, City Health). The plan tries to address all of the policies that can impact upon social inclusion and services for older people.

The plan has five major objectives in order to achieve this vision, these are:

1. To take forward the concept of integrated service management and access, which will be achieved through the Local Strategic Partnership’s endorsement of the plan.

2. To identify the future configuration and performance management arrangements of services for older people through mapping service provision, identifying areas of overlap, duplication and under-provision, agreeing models of future service delivery (to include structure, budgets and other resources, performance management and monitoring arrangements, customer promises and service standards), and the identification of the staff skills that are necessary to implement and deliver modernised services.

3. The implementation of a common strategic framework and integrated management approach through the agreement and implementation of charging policies, management arrangements around pooled budgets, joint assessment arrangements, review of the eligibility criteria (including joint
local and health authority eligibility criteria) and to agree and implement joint commissioning arrangements.

4. To establish integrated systems for the management and development of services for older people through agreeing protocols for sharing and dissemination of client and management information between partners. This includes identification of current and new information needs, information technology (IT) requirements, specification and procurement through to the implementation of an integrated, client based management information system/database.

5. To establish clear access to services and information to promote independence and choice through agreeing a joint public information and marketing strategy and promoting culture changes to joined up service information through the joint training strategy.

5.3.5 The implementation date for the completion of the plan was 1 April 2000, however within each objective, individual targets have been identified mostly requiring completion during 2003.

5.3.6 All Authorities are required to develop a charter: Better Care, Higher Standards. The charter for Hull sets out how Health, Housing and Social Services are working together to provide long-term care services for those who need them. It explains what help is available to meet needs and what service users can expect. It lays out the values of the agencies that are involved with service provision.

5.4 The Local Context - Training, Recruitment and Retention

5.4.1 Within Hull and the East Riding there is a 5.9% vacancy rate in the NHS and a 30% vacancy rate within Social Services (correct as at October, 2002). Although a number of these vacant posts have now been filled, existing staff have moved on creating more vacancies. These figures represent one of the higher vacancy rates for Occupational Therapists outside the London area.

5.4.2 Pay scales have been harmonised, to some extent, between the Health and Local Authorities; basic grade Occupational Therapists now earn roughly the same salaries regardless of the employing agency. However there does appear to be more opportunity within the Health Service to move to higher grades than within the Social Services Department.

5.4.3 Due to the current structure and working arrangements the shortage of Occupational Therapists means that the same people tend to move around between the Social Services Department and the Health Trusts in the area.

5.4.4 Following discussions with Occupational Therapists the following issues have been identified as probable reasons why Social Services, in particular, have difficulty in retaining, and to some extent recruiting staff:

   (i) Vacancies at Senior Management Level

       Although adequate management structures are currently in place, the major difficulty is caused by the fact that both managerial posts (Team Leader and
Senior Occupational Therapist) have been vacant since May, 2001 and January, 2001 respectively. One of the reasons suggested for these long term vacancies is that the Team Leader salary is only one spinal column point above that of the highest point of the basic grade Occupational Therapist. There is therefore little financial incentive to take on the extra management responsibilities that such a post requires.

The current vacancies put undue stress on basic grade Occupational Therapists and create tensions within the team that are not conducive to effective working or job satisfaction. In addition it creates problems with communication as there is no feedback system from staff to management and vice-versa. Due to the management vacancies Occupational Therapists are required to undertake management responsibilities such as attending meetings, service development, dealing with funding and provision issues, and supervision of their own colleagues. This extra burden is reducing the amount of time that Occupational Therapists have to spend with clients thereby indirectly increasing waiting lists and customers’ negative views of the service.

(ii) Inadequate Levels of Staffing

At present there are 7.3 whole time equivalent Occupational Therapist posts within the Physical Disability Resource, 4.3 of these posts remain unfilled and have been for some time (this does not include consideration of the above two positions). This shortage means that the Occupational Therapy Assistants (12 whole time equivalent posts with only 15 hours vacant) are being required to in-fill for the vacant qualified Occupational Therapist posts, and are now undertaking many assessments independently. This is viewed as devaluing the length of time it takes to train and qualify as an Occupational Therapist.

As noted above, the difficulty in filling the managerial posts has resulted in basic grade Occupational Therapists having to take on managerial responsibilities. This is compounded by the shortage of Occupational Therapists and has resulted in the current waiting list situation. It also provides a vicious circle whereby the shortage of staff makes working more negative and stressful, which means that more staff leave, continuing the cycle.

(iii) Social Services Occupational Therapists are not fulfilling the role of an Occupational Therapist

Partly due to the shortage of staff and partly for historical reasons, Social Services Occupational Therapists undertake no rehabilitative occupational therapy at all. Their remit is focused entirely on maintaining and improving clients’ quality of life through the provision of aids and adaptations. There is some feeling that this has de-skilled and devalued Social Services Occupational Therapists, allowing no time or opportunity to practice skills gained from training. This issue is exacerbated by the lack of opportunity to be seconded or rotated into posts which undertake rehabilitative Occupational Therapy.
It has been suggested that this is one of the reasons why graduates of Occupational Therapy tend to take a “Health Service” route as they feel that this will enable them to make the most of the skills that they have invested time and money in acquiring.

Further to this it is perceived that there is little ability to transfer from Social Services to health and maintain any seniority built up because a Social Services Occupational Therapist will not have gained the clinical skills that are required by the Health Service.

Finally, although there is little difference in starting salaries between Social Services and Health Services there is more opportunity for salary increases within the Health Service without having to take on a management role.

(iv) Lack of respect of professional judgement and skills

It has been suggested by most of the Occupational Therapists consulted that Social Services Occupational Therapists are perceived (by both Health and also other Local Authority Departments) as a “dumping ground” for referrals/enquiries that are ‘unwanted’, ‘miscellaneous’ or ‘too complex’ for other personnel/teams to deal with. However, the view is that these issues could easily be dealt with elsewhere most probably where the initial query originated from and should not become the remit of the Occupational Therapy Team automatically and almost by default.

Many of the Social Services Occupational Therapists feel that, perhaps due to a lack of managerial support, they have to constantly justify their actions and decisions and that accordingly they are given little professional respect. This view contrasts with that given by the Health Service Occupational Therapists who feel that they and their professional judgement are very highly regarded by colleagues and clients alike.

(v) Inadequate office premises

The Physical Disability Resource Team premises at Bellfield House are inadequate for such a large staff group. Occupational Therapists have to share desks and work in overcrowded conditions that are not conducive to a satisfactory working environment. The Occupational Therapists find it very difficult to go about their daily duties such as making and taking phone calls, writing up reports etc, due to the levels of noise and incidences of disturbance by colleagues etc. There have been suggestions however, that the team may soon be moving into new premises.

6 Service Providers

6.1 Introduction

6.1.1 Within the city of Kingston upon Hull there are a number of agencies that provide occupational therapy services. In addition, there are also some providers who work with patients across the city boundaries, taking patients from both the East Riding and the North East Lincolnshire areas.
6.1.2 This section outlines all the service providers encountered who operate within the Hull area, mapping (i) the remit of their service, (ii) the number of staff and vacancies within the service, (iii) the timescale that a typical case will remain with service, or in some cases the prescribed timescale the service is allowed to work with the client, (iv) the basic processes and procedures involved in providing the service, and (v) any general observations that have been made throughout the course of the enquiry.

6.1.3 A summary table of services provided is included at section 6.7.

6.2 Kingston upon Hull City Council Social Services Department – Physical Disability Resource

(i) Remit of the Service

Services are provided for residents of the city of all ages. Clients are referred either through other agencies (e.g. hospitals or community health) or through self or relative/carer referral. However, all referrals must firstly go through the care management system before they are referred to the Physical Disability Resource.

The focus of work is purely on providing aids and adaptations necessary to aid (independent) living. The Occupational Therapists do not provide any physical or rehabilitative therapy services such as improving mobility or retraining in living skills.

(ii) Staffing

The Physical Disability Resource comprises:

- 1 Team Leader – vacant since 23.05.2001
- 1 Senior Occupational Therapist – vacant since 01.01.2001
- 1 Moving and Handling Co-ordinator
- 7.3 whole time equivalent Occupational Therapists – 4.3 vacant posts
- 12 whole time equivalent Occupational Therapy Assistants – 15 hours vacant

In addition there are also administrative staff and staff working within the Joint Equipment Service (details of this service are contained in this report at section 6.3).

(iii) Timescales

The team is usually involved with clients in the long-term as equipment etc. will need updating/replacing dependent upon the progress and functioning of the client. It is apparent that once an Occupational Therapist has been allocated to a client they become an invaluable resource and, in some circumstances, they are perceived to act on the client’s behalf (by both the client and other departments) on most matters thereafter. Whether this is the most appropriate use of Occupational Therapists’ time is debatable.
(iv) Processes and Procedures

When a referral (usually through Social Service Care Management) is received it is classified as one of three priority categories:

Level 1 (a) Assessment required urgently – eg. problems with moving and handling, falls (excluding falls when using the bath), risk of family/home breakdown, terminal care, hospital discharge (non-standard discharges only).

Level 1(b) Assessment required as priority over all levels [excluding 1(a)] - children, deteriorating neurological conditions, sudden deterioration in self care skills, mobility issues, unable to access key facilities; re-housing assessment (only when property identified).

Level 2 – Bathing (when unable to maintain hygiene by themselves), stair mobility, re-housing (unless under level 1, if social move only under level 3)

Level 3 – Kitchen assessments (unless clear risk identified), bathing (when able to maintain hygiene by themselves), re-housing on social grounds (e.g. to be near family/carers).

Following any assessments and visits an Occupational Therapist will have to fill in a variety of documents for case files. This can take up a lot of the therapists’ time that may be better spent elsewhere.

Generally an Occupational Therapist will continue to work with the same client in order to build up a positive working relationship.

(v) General Observations

Occupational Therapists working within Social Services view their relationships with clients as very dynamic and developing relationships is an important part of their work. It is clear that often solutions to clients’ problems are arrived at through the development of the relationship and an almost “evolutionary” process. For example, in getting to know the particular personalities and needs of an individual client, an Occupational Therapist is able to tailor the use of aids and adaptations in an imaginative way to ensure that the client’s needs are met fully but more importantly that the client will be comfortable with the equipment and so use it successfully.

6.3 Hull City Council and East Riding Community Health NHS Trust – Hull Joint Equipment Service/Services to Aid Independent Living (S.A.I.L)

(i) Remit of the Service

The Joint Equipment Service is a partnership between Kingston upon Hull City Council and the Hull and East Riding Community Health NHS Trust. It provides access to a wide range of equipment to aid daily living and support nursing care eg. grab rails, sticks, zimmer frames, wheelchairs, bed risers
etc. The Joint Service aims to provide a delivery, installation and retrieval service for the above items.

The Joint Service is accessible and accepts referrals from all sources (i.e. self, GP, hospital, health and social services).

The charging policy is about to be changed due to the fair access legislation, which will effectively mean that clients will no longer be charged for equipment. At present the charging schedule is:

Items of a value less than £5: the client is charged cost price for the equipment;

Items of a value £5: non-refundable deposit of £5 (in effect a hire charge);

Items of a value greater than £5: non-refundable deposit of £5, client charged full price for the item however, a refund of the remainder of the item value upon return with receipt.

(ii) Staffing

The staff group consists of:

- 1 Stores Manager
- 1 Service to Aid Independent Living Manager (S.A.I.L)
- 15 Senior Assistant Technical Officers
- 5 Admin and Clerical Staff

From the information provided there appear to be no vacancies at present.

(iii) Timescales

Generally the timescales involved in providing equipment will be determined by its availability. This is outlined in section (iv).
Processes and Procedures

There have been many suggestions that the Joint Equipment Service is not as efficient or effective as it could be. There are often difficulties regarding the delivery, installation and retrieval of equipment.

It has been suggested that there are difficulties with the working relationships between staff within the Joint Equipment Service and Occupational Therapists. However, this is a one sided observation as the Joint Equipment Service has not been approached for comments.
6.4 Hull Acute Home Therapy Service (H.A.H.T.S) – Hull and East Yorkshire Hospitals Trust

(i) Remit of the Service

To provide a rehabilitation service to patients in their own home. Input usually, but not always, follows a stay in hospital. The aim of the team is to improve the patient’s quality of life by enabling the patient to be as independent as possible.

(ii) Staffing

- 1 whole time equivalent Head Physiotherapist
- 1 whole time equivalent Senior II Physiotherapist (vacant)
- 1 whole time equivalent Senior II Occupational Therapist (on rotation) (vacant)
- 1 whole time equivalent Senior I Occupational Therapist
- 3 whole time equivalent Technical Instructors
- 0.5 whole time equivalent Administrative Support

(iii) Timescales

HAHTS are able to work with a client for up to 12 weeks. It is expected that most patients will have completed their treatment within 12 weeks. If necessary, arrangements will be made to continue rehabilitation which may involve transfer to other rehabilitation teams. However, in practical terms this would be unlikely as there are few longer-term rehabilitative services available with those that are, only being offered through services such as the stroke service where waiting lists and times are inevitably high.

(iv) Processes and Procedures

There are a number of processes and procedures relating to H.A.H.T.S these are:

All patients must meet the following criteria irrespective of referral type:

(a) The patient must be resident within the boundaries of Kingston upon Hull, Anlaby, Hessle, Kirk Ella, Skidby, Willerby, Cottingham, North Ferriby, Elloughton, Brough or Welton;

(b) the patient must be 16 years of age or older;

(c) the patient must have been identified as having the potential to improve their independence and/or quality of life through a course of acute home therapy treatment lasting a maximum of 12 weeks using a number of indicators (these are available if needed);
The following criteria must be met if a patient is referred as a hospital inpatient:

(d) therapy outcome measures show a steady improvement in independence and/or quality of life over the last week prior to discharge from hospital;

(e) realistic goals set by the therapists are still attainable;

(f) the patient is an inpatient and is receiving treatment from a Physical or Occupational Therapist;

(g) the patient is referred by a consultant via the Multi Disciplinary Ward Team (MDT). The Physical and/or Occupational Therapist who is treating the patient must have been involved in the referral process,

(h) the patient has been identified to require short term therapy to prevent post-discharge deterioration and subsequent hospital re-admission.

The following criteria must be met if the patient is referred through their GP:

(i) the patient is not considered suitable for referral to existing GP Direct Access Services;

(j) the referral is related to the patient’s last inpatient episode to prevent a re-admission within a 6 month period and the condition to be treated by therapy intervention is related to the original reason for the in-patient admission.

The service does not provide for patients in the following situations:

(a) the patient has severe mental health problems;

(b) the patient is only ‘waiting’ for an additional long term service or facility;

(c) the patient has severe neurological or terminal health difficulties which would prevent them from benefiting, although advice and education can be given;

(d) the assessment of need or request for treatment is not clear or there is no explicit reason why the service is requested.

(v) General Observations

The HAHTS service tends to be used when it is evident that a patient may require a longer period of rehabilitative therapy than can be provided by the Intermediate Care Team. There appears to be no reason why a patient could not be referred to the HAHTS service following involvement by Intermediate Care, however, this would mean that the patient was subject to changing therapists.
6.5 Hull Intermediate Care Team (Hull and East Riding Community Health Trust)

(i) Remit of the Service

The Intermediate Care team is able to provide a 24 hour, 7 day a week service. The service is jointly funded by Hull and East Riding Community Health and Kingston upon Hull City Council Social Services. The service set out with the aim to provide a full care package to clients in Kingston upon Hull, however in reality this does not always occur. The team’s focus is the rehabilitation of clients over the age of 18 years, working in the community to promote independent living following an acute episode of illness or injury.

The main remit of the service is two fold:

1. To facilitate discharge from hospital as soon as possible.
2. To prevent admission/re-admission.

(ii) Staffing

The Intermediate Care Team is a multi-disciplinary team made of the following staff:

- 0.8 whole time equivalent Head of Occupational Therapy
- 3.5 whole time equivalent Senior Occupational Therapists
- 0.5 whole time equivalent Senior Physiotherapist
- 2.3 whole time equivalent Physiotherapists
- 0.5 whole time equivalent Physiotherapy Assistant
- 0.9 whole time equivalent Senior Dietician
- 4 whole time equivalent Technical Instructors

The team also includes a number of district nurses and administrative staff.

(iii) Timescales

The Intermediate Care Team is able to work with a client for up to 6 weeks. It is expected that most patients will have completed their treatment within 6 weeks. However, in practice this is not always the case. Patients are referred to the service regardless of the potential timescales involved, e.g. a stroke patient may be referred who may require longer term treatment. The Occupational Therapists will try to be flexible with these timescales but this is not always possible. In such cases the patient will then have to be referred onto another rehabilitation service. The problems then arise as discussed above at 1.3 within the HAHTS section.

(iv) Processes and Procedures

The Intermediate Care Team is able to take referrals from a variety of professionals, e.g. Physiotherapists, GP’s, District Nurses and Social Services (usually advice or assessment officers). The Occupational
Therapists working within the Intermediate Care Team are able to visit clients in their own homes or a residential establishment.

The Occupational Therapists from the Intermediate Care team tend to focus more on rehabilitative occupational therapy, although they assess for and are able to provide some minor aids and adaptations as necessary (usually items such as sticks, splints etc).

Following the expiry of the 6 week period, or rehabilitative work being completed (whichever comes first) the patient will be discharged from the service. If the patient requires further therapy they may be referred elsewhere.

(iv) General Observations

The Intermediate Care Team provides an invaluable service giving rehabilitative therapy to clients in a community setting. This service is generally unavailable through any other means apart from very limited community rehabilitation offered in relation to stroke services.

The team also has a joiner and technicians based with it which enables alterations to be made quickly and efficiently to enable its clients to be more independent.

6.6 Hull Royal Infirmary Occupational Therapy Team (Hull & East Yorkshire Hospital Trust)

(i) Remit of the Service

The Occupational Therapists based within this team work across all wards and disciplines within Hull Royal Infirmary.

The team works with patients to ensure that they are basically safe to return home, this is the main focus of work – to assess function, independence and safety. The team are not as concerned with what the client was previously able to do as to what they are able to do at present.

(ii) Staffing

The staff group within the Hospitals Trust is made up of:

- 8.25 whole time equivalent Senior I Occupational Therapists – 4.12 vacant posts
- 6.03 whole time equivalent Senior II Occupational Therapists – 3.79 vacant posts
- 6.92 whole time equivalent Occupational Therapists – 2 vacant posts
- 8.92 whole time equivalent technical instructors – 1 vacant post
- 1 whole time equivalent District Occupational Therapist
- 1 whole time equivalent Research and Development Therapist
- 8.73 whole time equivalent Occupational Therapy Helpers – 0.73 vacant posts
(iii) **Timescales**

The team works with patients whilst they are in the hospital.

(iv) **Processes and Procedures**

Staff are allocated to specialist teams e.g. orthopaedic/paediatric etc and therefore develop specialisms in their own fields, however most of the skills developed are transferable to other areas of the hospital.

The team receives referrals from ward staff (usually physiotherapists) and consultants. The team will accept a referral once the patient is able to stand with the assistance of one person.

Work will continue with the patient until the Multi-Disciplinary Ward Team, which meets weekly and includes ward representatives, Physical and Occupational Therapists, the Discharge Liaison Nurse, representatives from Hull Intermediate Care, and Social Services Care Co-ordinators (if appropriate), decides that the patient is safe to return home and will then refer the patient to the appropriate agency.

The team is able to assess patients within the hospital setting and has a kitchen set up to do this. They are also able to do home visits with the patient to assess their functioning in their home environment.
### 6.7 Summary Table of Service Provision

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Physical Disability Resource (SSD)</th>
<th>Joint Equipment Service (SSD+ ERYC+ HERCH)</th>
<th>Hull Acute Home Therapy Service (HEY)</th>
<th>Hull Intermediate Care Team (HERCH+SSD)</th>
<th>Hull Royal Infirmary OT Team (HEY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Hull Boundary</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Inclusive of Surrounding Areas i.e. Hessle</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Age range (unlimited=✓)</td>
<td>✓</td>
<td>✓</td>
<td>16+</td>
<td>18+</td>
<td>✓</td>
</tr>
<tr>
<td>Provide Equipment</td>
<td>✓</td>
<td>✓</td>
<td>?</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provides Rehabilitation</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Takes Terminal Patients</td>
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<td>✗</td>
<td>✗</td>
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<td>✗</td>
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<td>6 weeks</td>
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<tr>
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<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>Home Visits/Community Service</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>occasionally</td>
</tr>
</tbody>
</table>

**KEY**

N/A= Not Applicable for this service

* “improvement” in this context refers to increasing ability to function independently

SSD=Social Services Department / ERYC=East Riding Of Yorkshire Council / HERCH=Hull & East Riding Community Health Trust / HEY=Hull & East Yorkshire Hospitals NHS Trust
7 Issues and Problems Associated with Local Service Provision

7.1 The lack of an integrated system for recording patient notes and sharing patient information between involved agencies.

7.1.1 This was cited as the main difficulty faced by Occupational Therapists working across all agencies. There is a degree of unwillingness to share patient records with other agencies as these records are easily mislaid or lost, thus making the originating agency’s files incomplete. Unfortunately the lack of information sharing means that assessments are often duplicated and Occupational Therapists are often unaware of what other agencies may or may not be providing to a particular client, both before and after the incident of illness or injury that has led to them requiring Occupational Therapy input. It is often up to the Occupational Therapists themselves to ask the client what health and social care services and equipment they have received or are receiving. Understandably this information is not always correct or can be convoluted and it may take some time for the Occupational Therapist to find out the true level of service provision or function. This obviously takes up therapists’ time that could be better spent actually treating the patient.

In response to section 7.1 the Commission is aware that a system is currently being developed in relation to children’s services in the city - Pathfinder. This system is based on ‘hub’ technology (see fig 1.) and will allow a range of professionals to update and view information about mutual clients. The system will be operational from the end of May, 2003.

A bid was put into the Office of the Deputy Prime Minister for funding to provide for additional service area roll-outs, however this was unsuccessful. There was no feedback given as to why.

There are a number of benefits that are provided by this system including:

(i) Increased productivity as a result of fast and effective information exchange, staff are no longer dependent on other personnel being available at the time they require information;

(ii) Improved co-ordination of services and avoidance of duplicating information, in line with Government objectives for joined up services and closer working relationships;

(iii) Each organisation benefiting from the transfer of knowledge, skills and expertise as a result of partnership working;

(iv) Enhanced functionality and capability as a result of linking separate source systems - they are now multi agency support systems;

(v) Having access to integrated systems will assist with inter agency working reducing time wasted in trying to establish other agency involvement, prevent duplication of work and streamline resources;

(vi) The project has provided solutions to Data Protection issues and information sharing and this has been shared with other organisations;
(vii) Administration will be reduced as professionals are directly equipped with the means of searching for information themselves, thereby not relying on support staff or other personnel to find information on their behalf;

(viii) The product is web based and is available to both static terminals in offices and by using hand held devices, therefore individuals are better able to respond in the field because of a fast and effective means of information exchange;

(ix) The project has assisted in an area of practice that has previously underused technology and consequently had skill deficits within the profession;

(x) Informed and joined up decision making through fast electronic exchange of information will improve practices 24 hours a day, 7 days a week, 365 days a year;

(xi) Revision of policies, leaflets and public documentation about management of information, providing the customer with a better understanding of information systems and how to access information held on them.

There are however some difficulties in implementing such a system, especially in relation to adults services, these include issues such as:

(i) Data Protection Act

(ii) Human Rights Act

The Data Protection issues are mainly in relation to obtaining consent from vulnerable adults i.e. those with learning difficulties. The Human Rights issues are associated with the storing of such information.

![Diagram](image)

*Fig 1*
7.2 The lack of a dedicated medium to long term rehabilitative community Occupational Therapy Service

7.2.1 Rehabilitative occupational therapy within a community setting is provided by the Intermediate Care Team, Hull Acute Home Therapy Team and also home visits from acute Occupational Therapists (Hull Hospitals) although only for assessment. This means that there is very little prospect of a client being able to have rehabilitative occupational therapy following Intermediate Care’s 6 week cut off period. This presents a particular problem for patients who have had strokes etc which, although they may be able to regain a level of independence have no long-term rehabilitative occupational therapy input, unless they are able to access the limited service offered by the stroke service. Such a client may however receive support from Social Services although this will be on the basis of providing aids and adaptations to assist with everyday living.

The main focus of work for Social Services Occupational Therapists is assessing for and providing clients with aids and adaptations. Other agencies refer most major aids and adaptations to Social Services for assessment and fitting. There is therefore, little scope for an Intermediate Care OT to influence or chase the required aids and adaptations which can cause a delay in the implementation of rehabilitation work. This focus also leads to little, if any, opportunity for Social Services OT’s to carry out rehabilitative work in the community.

7.3 Delays and difficulties in providing clients with equipment that meets their needs.

7.3.1 It has become clear, from discussions with both staff and clients, that there can be some delays and mistakes in providing equipment. This also means that Social Services Occupational Therapists are spending unnecessary time chasing up equipment.

In addition to this, in some cases when an item is delivered the technician delivering it will take away another item that they consider will no longer be of use to the client. This is not always the case, as Occupational Therapists work in imaginative ways to meet clients’ needs and may have envisaged a unique way of using a piece of equipment that has not been considered by the technician.

The delivery of equipment also causes difficulties as it is not always possible for the Occupational Therapists to be present when the item is delivered. This is due to the way in which deliveries and orders are handled – it would obviously be impractical for an Occupational Therapist to spend half a day waiting at a client’s home for a delivery of equipment. However as the Occupational Therapist is not always present, a client may not be instructed on how to use the equipment and this may then cause a hazard to themselves, or they may dismiss the equipment as of little use before they have really been given an opportunity to use it in the way the Occupational Therapist intended.
7.4 Referral response times for Social Services are reported to be very poor, and waiting lists are unacceptably long.

7.4.1 In some cases referral response times are very poor. Some clients have waited approximately 6 months before they have been assessed by an Occupational Therapist or an Occupational Therapy Assistant. The general opinion is that this is mainly due to the poor staffing levels within the department. The situation is also exacerbated by the current prioritisation criteria, as described in section 1.1 (above). Due to the volume of urgent and level 1 cases, clients with referrals at level 3 are continually at the bottom of the list.

Current waiting times are shown at Appendix 1 (for definitions of priorities see section 6.2 [iv]).

There are also a number of other cases on the waiting list i.e. technicians, housing and simple service, these total 370.

This brings the total number of cases waiting for action to 717.

7.5 Many clients require a variety of services at any one time, and each service can complement the work of the other.

7.5.1 Some clients require a multitude of therapy services that are unable to (currently) be provided by one particular agency. This can lead to a duplication of work and effort, and confusion and frustration for the client.

For example, one of the main difficulties for the Intermediate Care Team Occupational Therapists is that a lot of their patients require speech and language therapy, but the waiting list for these services is extremely long. It may be beneficial to have a speech therapist based within the team. There is however, a skills shortage within speech and language therapy.

In addition, occasionally a client will be unable to make progress in one area until another area has been addressed.

8 Conclusions

8.1 It is clear from our enquiries that there are many gaps within the service, many of which could be addressed by improved communication between all agencies.

8.2 The Commission felt that there is a clear need for a community rehabilitative occupational therapy service or at a minimum scope for Social Services, or Health Occupational Therapists already working within the Community to work with clients on a longer-term basis. Following discussion with the Occupational Therapists from the Intermediate Care Team it was apparent that the majority of cases could be assessed as either being (a) short term or (b) medium to long term upon initial referral. One possible way of implementing this would be to reduce the amount of simple aids and adaptations that are provided by a Social Services Occupational Therapist. However, this may not be possible as much of this equipment is very specialised.
8.3 The Commission also believed that it would be very helpful for every client to have a key-worker who takes on a care co-ordination role across all service areas.

8.4 The Commission felt that an increase in the cost effectiveness of providing aids and adaptations, and also a reduction of the amount of time an OT spends doing administrative work, could be achieved by developing a catalogue of equipment and establishing a demonstration centre where clients could come along and be assessed and shown how to use equipment appropriately. A client could then order the exact piece that they require (or this could be done on their behalf by an OT) and this could be collected from the Joint Equipment Store or delivered by a variety of means. The Lead OT within Hull Royal Infirmary indicated that a catalogue of common equipment that could be made easily available would be very helpful in their area of work.

8.5 The Commission believed it would be helpful to have a specific member of staff who deals with requests for equipment to take this largely administrative task away from Occupational Therapists.

8.6 The Commission believed that it is important that the practice of manually writing case notes up when returning to the office is phased out. All Occupational Therapists and Occupational Therapy Assistants within the Social Services Department should have access to voice recording equipment (Dictaphones) to enable dictation of case notes. Administrative staff should then type up the case notes, freeing up some Occupational Therapist and Assistant time.

8.7 The Commission feels that it is imperative that the waiting list is reduced as soon as possible. The recommendations and conclusions from this report and the findings of the rehabilitation strategy group should impact upon the waiting lists.

8.8 If we are to look forward to solving one of the main issues that is affecting occupational therapy services within the city - recruitment and retention of staff, we must offer potential Occupational Therapists a forward-thinking and pro-active organisation to work for. At present this is not the case within this city.

9 Recommendations

Based on the evidence heard the Commission concluded that it would be necessary and useful to set a number of short and long term recommendations. The Commission therefore agreed that the following short-term recommendations should be implemented by April 2004.

9.1 Short-term Recommendations

9.1.1 That all of the Health Trusts operating within the City ensure that they work jointly with the Social Services Department on the development of services.

9.1.2 That at a minimum, a small, preferably central, needs assessment and demonstration centre be set up where clients can collect equipment.

9.1.3 That a catalogue of common equipment should be developed for use across all agencies.
9.1.4 That a specific member of administrative staff should have responsibility for requests for equipment.

9.1.5 That, subject to a feasibility study to establish if there is sufficient administrative time, all Occupational Therapists and Occupational Therapy Assistants within the Social Services Department should have access to voice recording equipment (Dictaphones) to enable dictation of case notes.

9.1.6 That, due to the duplication of effort, the use of locum/bought in Occupational Therapists be avoided where possible.

9.1.7 That staff development and training should be implemented. A reciprocal rotation system that is in place in relation to Hull Royal Infirmary should be broadened to encompass the Intermediate Care Team. Staff should be encouraged to take on rotations as a way of developing their skills.

9.1.8 That career development for Occupational Therapy Assistants who wish to undertake appropriate training and qualifications should be promoted.

9.1.9 That Occupational Therapy as a career option should be actively promoted. This should be done through stands at careers events and road-shows. Information should also be provided to schools and colleges etc. to encourage young people to think about Occupational Therapy as a career option.

9.1.10 That detailed consideration be given to dedicated advice officers being based within the Occupational Therapy Team.

9.1.11 That the Committee supports the Social Services Department Occupational Therapy service in its bid for premises at Mount Pleasant.

9.1.12 That the Council nominates a ‘champion’ to represent the Occupational Therapy service.

9.2 Long-term Recommendations

The Commission agreed that the following long-term recommendations should be implemented by April 2007 with the aim of providing a seamless service for clients through a multi-agency team that can effectively follow a client through every step in the rehabilitation process and also provide clients with assistance in relation to equipment, aids and adaptations. Where possible a client should have an Occupational Therapy key-worker who is able to remain with the client throughout involvement.

9.2.1 That Social Services works with other agencies involved to ensure that the processes, systems, finance and organisational (including administration) arrangements are effective and in place in order to facilitate the long term plans.

9.2.2 That a comprehensive multi-agency integrated occupation therapy team be established which should incorporate both intermediate and long term rehabilitation.
services and the promotion of mobility and independence through provision of aids and adaptations. The integrated team should include both NHS agencies and Social Services.

9.2.3 That the implementation of a Key Competency Scheme aimed at encouraging staff to develop a wide variety of expertise should be considered in detail.
## Appendix 1

<table>
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<tr>
<th>OT</th>
<th>August and before</th>
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<th>Oct</th>
<th>Nov</th>
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<th>Jan</th>
<th>Feb</th>
<th>March</th>
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<td>19</td>
<td>25</td>
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<td>53</td>
<td>164</td>
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</tbody>
</table>

**KEY**

OT = Occupational Therapist  
OTA = Occupational Therapy Assistant
Appendix 2

Councillors involved in the enquiry:

Councillors  Burton  
              Butterworth  
              Clark  
              Ellis  
              Glew  
              Hancock  
              Hewitt  
              Lowery  
              Page  
              Petch  
              Wastling  
              White  
              (Mrs) K. Woods

Former Councillors Godden and Obridge