Occupational Therapy for the People of Cumbria

Cross-organisational Working Agreement

To Promote joined up working across Health and Social Care and improve the service user's journey

Introduction

The main purpose of this document is to set out the responsibilities of the full range of Occupational Therapy Services for the Cumbrian population with the aim of

- Putting the service user at the centre of what we do
- Enhancing the service user's experience of OT provision by promoting a safe, coordinated approach across services and organisational boundaries
- Avoiding duplication of service/effort wherever possible
- Providing clear parameters for the provision of Occupational Therapy resources and expertise.
- Providing integration and a smooth transition for services users of all ages moving between services and agencies
- Supporting opportunities for joint working & collaboration between services to improve outcomes for Service Users.

Roles and Responsibilities

The assessing OT will be responsible for the interventions identified. Any ongoing intervention e.g prescription or adaptation, rehab or treatment plan (physical or mental health) should be reviewed as required as part of the overall holistic approach prior to discharge or transfer. It is essential that third sector and community assets are considered and used appropriately to achieve this.

People with complex needs including those with complex physical and mental health needs those transitioning between children's and adults' services and those who may require long term adaptations, bespoke equipment and/or specialist services may require joint working and negotiation between services. In these situations the scope of each OT's involvement should be negotiated and recorded to ensure clarity of roles. This will include the type of intervention, likely duration and should be clearly documented within the person's notes and communicated to the person. All service users discharged from any service should be issued with contact details which includes the name of the OT or the service. Any identified gaps in service should be escalated to a more senior level.

- All service users referred for an OT assessment during an acute admission will remain the responsibility of the acute hospital OT in line with the agreed pathway in the trust. Any onward referral to another service will take account of the nature of the intervention required to meet the person's identified needs and the relevant assessment documentation will be forwarded to the receiving service via the agreed format (usually, electronic). Where a service user has been referred for an OT assessment during an acute admission and has on-going needs identified for OT intervention after discharge, this will be provided by the acute hospital OT or relevant community services in line with locally agreed pathways (including D2A). Agreement on which service will be responsible will take account of any need for

specialist expertise, as well as adhering to the principles outlined in the Introduction above.
If there is no OT involvement during acute admission, then the service users should be referred to Adult Social Care or Children's/Young People's OT service for long term needs or community rehabilitation services if they have a short term need identified after discharge.

- If the service user requires further involvement and there is a doubt regarding the most appropriate service a joint visit should take place between the relevant OT services.

- All service users with a short term need within the community who have a reduction in their occupations and have rehabilitative potential, or who are at risk of acute admission will be the responsibility of the appropriate community rehabilitation service or admission prevention team.

- All service users in the community experiencing a reduction in their occupational performance due to a long term need, or have reached maximum rehabilitation potential with a rehabilitative or reablement service and have ongoing needs, will be the responsibility of Adult Social Care unless eligible for a specialist NHS service in relation to their condition.

- If there is a need for specialist intervention e.g adaptation, equipment, mental health support, it is essential that third sector and community assets are considered and used appropriately. To achieve this advice for a service user on an in-patient unit, the service with the requisite skills in the service user's locality will provide advice and/or joint work.

Equipment

Please see Inspection of community equipment procedure (Appendix 1, on ELMS link page)

Minor Adaptations

All adaptations require a visit to the service user's home prior to recommendation.

These will be assessed by the appropriate practitioners involved with agreeing and delivering the programme. The duty of care to follow-up prescribed adaptations remains with the prescriber unless a transfer of care has been accepted.

Unless essential for safe discharge, or as part of the rehabilitation or reablement plan, these should not be considered if the service user is undergoing a period of rehabilitation due to potential for improvement in a person's occupational performance.

Any minor adaptations delivered by local authority services will be subject to the requirements of the Care Act 2014 (in relation to adults) and the Chronically Sick and Disabled Persons Act 1970 (in relation to children/young people).

Transfer Guidelines

Every referral will be accompanied by necessary supporting documentation. The transfer checklist can be used as an aide memoire (See Appendix 2).A copy of the referral will be retained by the referrer and the responsibility of care will only pass from the referrer once the referral has been accepted. Best Practise will include telephone liaison with the receiving OT to discuss the case.

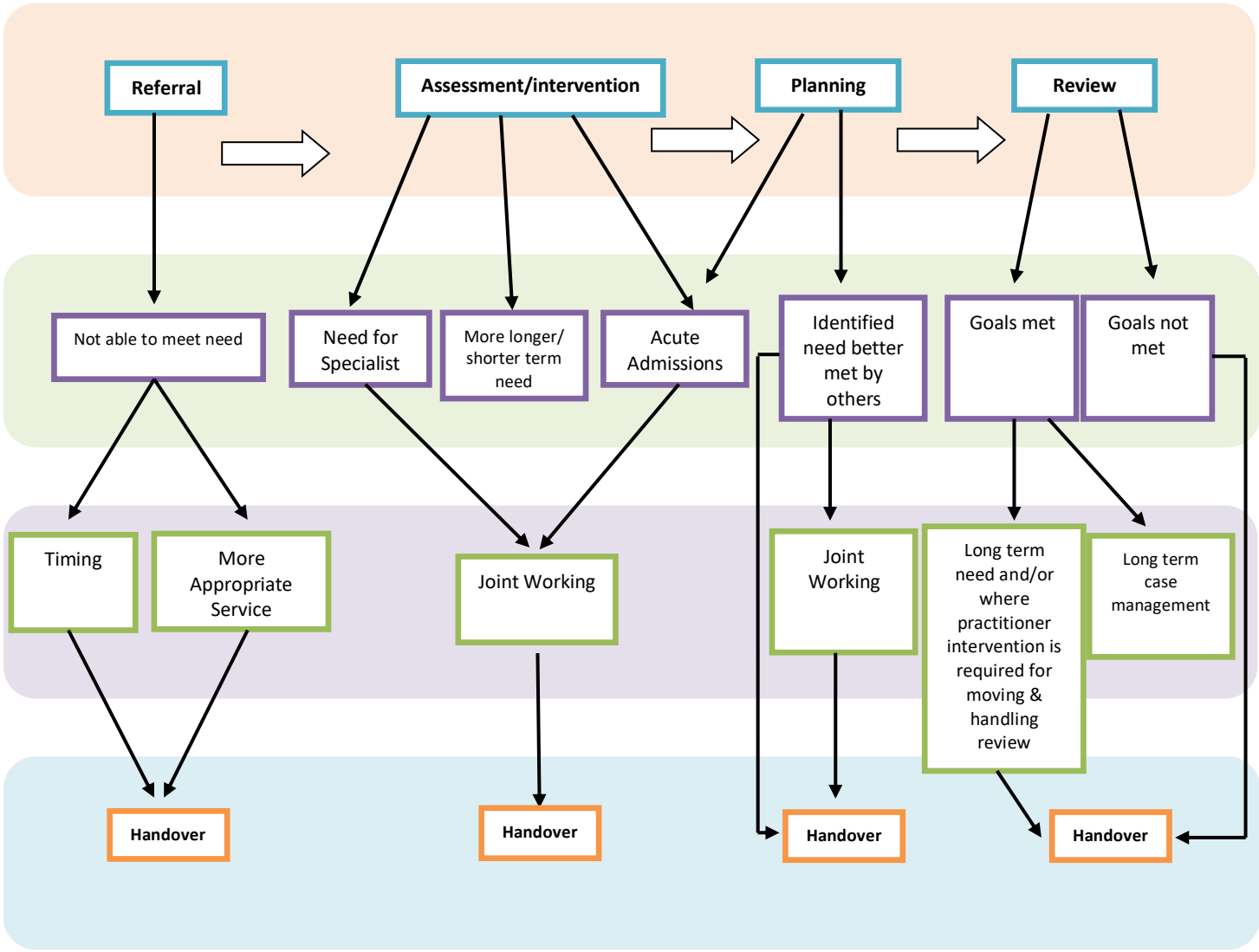
Interaction with existing legislation, guidance and operating procedures

This guidance does not alter or amend any organisations duties under health and social care legislation including the Care Act 2014, the National Health Service Act 2006 and the Mental Capacity Act 2005. All organisations will continue to comply with their respective duties in accordance with relevant regulations and statutory guidance including the Care and Support Statutory guidance and the NHS Standing Rules Regulations.

All OTs should understand the legislative frameworks in which they operate and be able to explain these and facilitate transfers to an alternative OTs where appropriate and necessary. Existing internal guidance and standard operating procedures will continue to apply and any conflicts between this guidance and other existing guidance should be brought to the attention of senior managers as a matter of urgency.

OT Process

OT transfer Process highlighting the times at which transfers of care may happen and when documentation handover is needed OT transfer Process highlighting the times at which transfers of care may happen and when documentation handover is needed:



Out of area and private hospitals

Service users returning to their own home from a stay in an out of area acute hospital with an ongoing short term need, will be picked up by the community rehabilitation services or joint worked with Adult Social Care if there is a long term need. Responsibility for communicating need lies with the referring OT.

Children returning from an out of area admission will be referred to the Children's/Young People's OT service to determine assessment of need.

Elective out-of-area surgical service users who require community equipment only, will be referred to the *most appropriate* local hospital OT for provision/prescription.

Where a service user requires further assessment/intervention following a private hospital discharge this responsibility will lie with community rehabilitation services. It is the responsibility of the OT receiving the information to signpost the person to the appropriate community team.

Equipment to Residential/Nursing

Consideration of the availability of suitable equipment should be given when discharge planning to nursing and residential care settings. Refer to appropriate policy. Please note that there will be contractual differences between Adult Social Care and Health funded placements. i.e. Equipment in Residential Care Homes and Nursing Care Homes- updated February 2019.

Clients visiting Cumbria

Acute illness with an admission to hospital will be the responsibility of the OT in the acute hospital following the normal admission process. Care will be transferred out-of-area at the end of the admission by the Acute OT if appropriate.

Service users visiting family or going on holiday in Cumbria will be expected to retain responsibility for their own equipment needs, this can be hired through 3rd sector organisations or local and national retailers.

Glossary

OT Specialist Services – Any service that includes OT which does not fall under the umbrella of Acute, physical health, Adult Social Care or community rehab services.
Adaptation – see Appendix 2
Joint Working – A joint assessment of a service user preceding a transfer of care or to gain specialist knowledge and skills and agree roles and responsibilities
Short term – within 6 weeks
Signposting – to give advice and information of available services for onwards referral

Agreed by on behalf of organisation

……date ……

Catherine A Walley ……date 14 June 2021

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