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SWITCH Partnership

Service System Redesign and Practice Development

Summary Report

August 2009

Background

The SWITCH Partnership developments aim to provide a modernisation framework for Allied Health Professions across Health and Local Authority organisations. This initiative has evolved out of a Knowledge Transfer Partnership funded project, focused on completing practice development changes, combined with an outcomes focused service system redesign within older adult and stroke occupational therapy services. A mixed methodology was adopted to establish a service baseline to provide evidence for change that informed the development of the service redesign model. The methodologies included service mapping; retrospective case record analysis; time and motion; professional focus groups and in-depth interviews with patients/service users and carers. The project provides an opportunity for significant shared learning across Allied Health Professions and Nursing.

Health & Social Care Policy Priorities

The partnership will deliver on a number of Health and Social Care Scottish Government drivers through the implementation of the practice and system service redesign model. These are:-

- AHP Rehabilitation Framework
- Shifting the Balance of Care
- Single Shared Assessment
- Intermediate Care and Re-enablement agendas
- Personalisation agenda
- Reshaping Older People's Services Programme
- Integrated Resource Framework
- Long Term Conditions Programme

Aim of the SWITCH Partnership

The SWITCH partnership aim is to:

"Implement a whole system and practice based change, directed to provide evidence based and efficient service arrangements that deliver person centred, community based re-enablement services that promote continuity of care"

This aim was directly derived from the baseline data gathering activities, where significant context specific evidence was generated to shape and influence the focus and activity of the partnership. The following outlines the key baseline evidence indicators for change.

Key Baseline Evidence Indicators for Change

The baseline data provided the evidence for the following key indicators for change:

Service/ Organisational Indictors;

- Existing Acute, Primary Care and Local Authority occupational therapy services lack a unified strategic focus.
- Professional practice is primarily based on "custom and practice"

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- Absence of Single Shared Assessment framework for occupational therapy services across Acute, Primary Care (COE and Stroke) and Local Authority services within the South Lanarkshire catchment area.
- Performance management information systems are not unified and are limited to input and output with no service outcome measurement to reflect person centred quality indicators.

Pathway/Resource Indicators[1];(Hairmyres /E.K Context)

- 43% (787/1816 referrals) of health referrals are transitioned to another occupational therapy service in any single care episode
- 13% of patients admitted to Acute COE and Stroke wards are known to LA O.T's, equating to 226 patients/service users per annum.
- 47% (£334k) of staff costs (£707K) are absorbed in duplicate activity associated with initiating and receiving transition of care episodes throughout the care pathway.
- Average patient/service user "wait" time between services equates to 38 days
- Occupational therapy Acute care length of contact extends by 28 days to 49 days(average 21 days with no follow up) when an O.T. transition is required, equating to £3.5million in bed day costs
- Current levels of homecare provision exceed level of need. South Lanarkshire Council O.T homecare review pilot evidenced a care cost reduction of £180k equating to 33% reduction from the original care group costs (n=97)

Person Centred Indicators;

- Service arrangements are fragmented, inaccessible and difficult to navigate for the patient/service user and carer
- Service arrangements require patients/service users to repeat information at each stage of the care pathway
- Service arrangements result in poor communication to family/carers
- Service arrangements are inefficient in their use of resource and are not personalised or needs led
- Service arrangements promote risk aversion by professionals and result in dependency for patients/ service users
- Service arrangement are not 'fit for purpose' and result in poor patient/service user outcomes

The baseline indicators present significant whole system service issues from the patient/service user, professional and organisational perspectives. These arise as a result of the pre-existing organisational cultures and practice norms; and the intra and inter organisational service arrangements and systems. These multifaceted elements cumulatively shape the nature of services delivered and service redesign requires to address each component to affect sustainable change. SWITCH utilised the theoretical framework of "Continuity of Care" to inform and direct service developments. The continuity of care framework provided the cohesive structure from which all the component service developments united. Continuity of care occurs at three levels. These are:

Informational continuity of care – "Efficient and effective transfer of information and accumulated knowledge of service user/patient, in order to bridge separate care events and ensure current care is appropriate for the patient/service user as they move from one care setting to another.

[1] All data presented represents Hairmyres Acute, Primary Care and East Kilbride locality older adult and stroke occupational therapy services, as relevant to the proposed area for the transitions of care pilot activity

Management continuity of care – "Consistent and coherent approach to service provision (care protocols, shared management plans, etc.) to ensure care from multiple providers is connected, orderly, complementary and timely.

Relational continuity of care – "Ongoing therapeutic relationship between provider and service users/patientt that bridges past to current and future care".

(Haggerty et al, 2003; Holland & Harris, 2007; Cameron et al, 2006).

Literature to date would suggest that Health and Social Care service redesigns have focused predominantly on the first two components of continuity of care, i.e. the informational and management aspects, at the expense of the relational component of continuity of care. The SWITCH partnership has actively sought to address all three components of continuity of care to ultimately achieve the overall aim of the partnership. This has required significant activity in the introduction of key complementary mechanisms for change within the cultures, practices and systems across Acute, Primary Care and Local Authority services.

Key Mechanisms for Change

The mechanisms for the culture, practice and system changes are derived from the baseline data and are as detailed below with an indication of their primary contribution to the continuity of care agenda:

1. Creating **shared organisational ethos and service priorities** *(Management Continuity of care/ Culture change)*
2. Implementing a **unified evidence based approach** to practice *(Management Continuity of care/ Practice Change)*
3. Developing and implementing a **Single Shared Assessment** and **Outcome Measure** I.T. infrastructure *(Informational Continuity of Care/ systems Change)*
4. Implementing a **unified approach to operational management** *(Management Continuity of Care / Systems Change)*
5. Implementing service infrastructures to facilitate **in-reach/outreach and extended duty of care** practices across Acute, Primary Care and Local Authority to **minimise the incidence of transitions of care** and **adopt a re-ablement approach** to service intervention. *(Relational Continuity of Care/ Practice Change)*
6. Creating and utilising **evaluation approaches for continuous improvement** *(Management Continuity of Care/Systems Change)*

1. Shared Organisational Ethos and Service Priorities

"Continuity of care" was quickly established as the inter-organisational service ethos by engaging service personnel in reviewing the baseline data results. The focus of the service redesign would be on improving the patient service user pathway through mechanisms that promoted continuity of care. The SWITCH shared service priorities were agreed to reflect the discrete pre-existing organisational service priorities across Acute, Primary Care and Local Authority. These include:

- Timely discharge from hospital,
- Focus on community re-enablement[2] and
- Provision of equipment and adaptations.

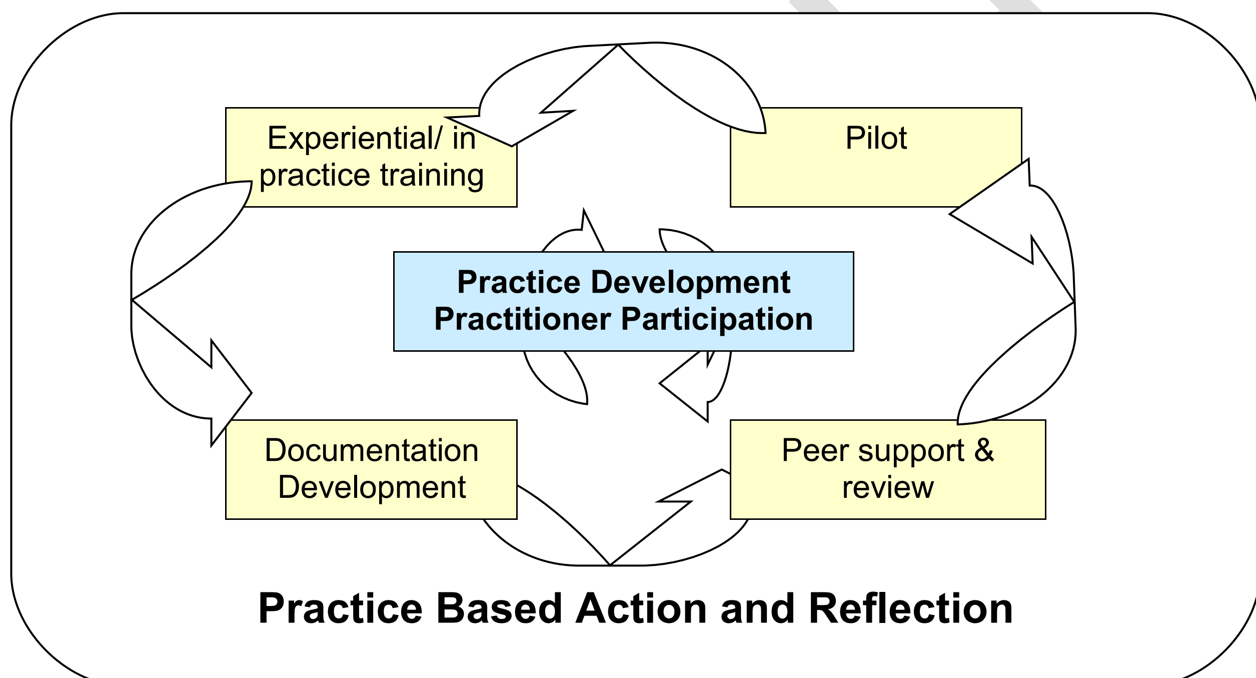
The priorities themselves were familiar to service personnel, but the key difference introduced by the project was that service personnel and management would now assume responsibility for all

[2] Re-enablement within this context focuses on delivering enabling programme of intervention to promote independence with meaningful activities of daily living, whilst reviewing appropriateness of homecare and environmental supports relative to individuals functioning within their home environment

three service priorities in practice, irrespective of their employing body. This unification serves to support services to become less organisationally driven and boundaried and more person centred. The creation of a unified service ethos, with shared service priorities is a prerequisite to creating a culture where the introduction of a range of change mechanisms, (aimed at unifying services in the interest of patient/service user continuity of care), are understood, accepted and adopted by service personnel, managers and organisations.

2. Unified Evidence Based Approach

The practice development implementation required multiple aspects to be coordinated and considered to affect practice change that was relevant, embedded and 'real' for practitioners. The key aspects of this includes; practitioner participation; pilot completion; experiential/in practice training; documentation development; peer support and review and the resultant link to continuing professional development. Figure 2 illustrates the cyclical and emergent process during the practice development phase.



In summary, an evidence based practice approach has been implemented (Modified Barthel Index & MOHOST) to inform evidence-based decision-making and enable person centred service outcomes to be recorded. The practice developments have directly linked to KSF/PDR requirements and HPC registration requirements. As a result of this multifaceted and participative approach to practice development a total of 130 staff have been trained and are proficient in a shared evidence based approach to practice across Acute, Primary Care and Local Authority services.

3. Single Shared Assessment (SSA) and Outcome Measurement

The development of a physical disability specialist IT module to compliment the existing SSA system was a developmental priority within SWITCH. The I.T. solution created underpins and supports a number of the redesign service developments, whilst simultaneously establishing these developments into mainstream health and social care occupational therapy services and the extended multidisciplinary context. The process of design and development was a collaborative approach between IT services, and the partnership. This was informed by the practice experience of the partnership piloting the evidence-based approach in paper format. Additional priorities in terms of performance management information and government priorities were also indicative in informing the content and design of the module. The shared module incorporates the evidence-

based assessments (MBI and MOHOST), along with goals setting and prioritising structures and supports to further develop a unified approach to practice in line with the unified service ethos and shared service priorities. These developments meet the national minimum data sharing standards. The performance management functions incorporated into the module provide not only service input and output data but also evidence based person centred outcome data. This provides opportunities to collate comprehensive patient/service user data across the whole system, creating patient/service user assessment and outcome profiles to inform future service developments. A total of 57 staff have been trained in the use of the Single Shared Assessment and outcome measure IT module. This includes staff working across Acute, Primary Care and Local Authority. The I.T. solution, although primarily contributing at an informational level of continuity of care through single shared assessment activities, it also creates the system infrastructure to develop and implement change mechanisms at a management level of continuity of care. Within SWITCH, the unified I.T. approach underpins the unified operational management of services across organisations to deliver a consistent and coherent approach to service provision across Health and Social Care.

4. Unified Approach to Operational Management

The unified operational management arrangement transcends multiple services including Acute Care wards, Early Supported Discharge Team, Day Hospital and Local Authority services. This has required significant levels of negotiation with the existing management arrangements in order to agree with all stakeholders their participation in the pilot of unifying the approach to the operational management of services.

The operational management arrangement is underpinned by the unified service ethos and shared service priorities, complemented by the bespoke shared IT system. This system provides a singular and practical service framework that unites the management approach to service referrals, allocations, caseload management and case closure/ discharge arrangements. The system and the unified approach to the operational management of services enables the identification and allocation of service users to the practitioner with whom they are known, irrespective of the stage of the care pathway. The unified management approach also provides equity in terms of focusing and targeting practitioners, irrespective of traditional organisational role, on the shared service priorities i.e. timely discharge from hospital; community focused re-enablement services and equipment and adaptations. The unification of the service system and management approach across the Acute, Primary Care and Local Authority services serves to establish the foundation from which service developments that promote relational continuity of care can be progressed in the form of in-reach and out-reach practices and extended duty of care.

5. In-reach/Outreach and Extended Duty of Care

Relational continuity of care requires practitioners to adopt an extended duty of care role. This requires Acute practitioners to follow service users from hospital into the home for re-ablement and/or equipment/adaptation provision; and Primary Care and Local Authority practitioners to assess individuals in the Acute phase and to support them home with re-ablement and/or equipment/adaptations within the community setting. The staff across all sectors are directed and supported to fulfil the shared service ethos and priorities by having extended access to resources (equipment/adaptations and homecare), enabling them to meet the needs of the patient/service users without having to refer on to another service. This achievement serves to improve the patient/service user experience of the care pathway, whilst simultaneously creating organisational efficiencies as the duplicate activity associated with transitions of care are minimised.

6. Evaluation Approaches for Continuous Improvement

Within the SWITCH partnership two research approaches have been adopted to inform, underpin and provide understanding of the process of implementation within the practice and service system redesign. These two approaches are Action Research and Realistic Evaluation.

Action Research

Within the SWITCH partnership emergence, knowing in action/ reflection and valuing experiential ways of learning, have been key components of the implementation phase embedded within an action research approach. The application of this approach has enabled tracking of action and reflection cycles through the practice development change to understand and adapt implementation approaches accordingly to support practitioners. This has been supported by a co-operative inquiry group, consisting of SWITCH Lead Practitioners from Health and Social Care to provide a reflective group forum to evaluate the action taking place within practice. This central group focus then feeds multiple communities of inquiry across the 12 geographical localities and services involved within the SWITCH partnership. This creates an environment for shared learning and mutual support and reflection; essential components required to create ownership and participation to achieve sustainable change. The emphasis on ownership and participation during the implementation and evaluation phases of the SWITCH partnership is a key feature of an action research approach.

Realistic Evaluation

A realistic evaluation approach has been adopted to understand the complexities of system change in the context of the service redesign. This approach provides a framework to identify the structures, resources, behaviours and interactions that generate the tendency for events to occur or not to occur within specific organisational and service contexts. The approach tests system changes as they are implemented, providing the evidence and structure to amend ineffective systems within the change process, to ensure that the service redesign implemented is effective. This approach combines empirical data and the views of personnel at all levels from Health and Local Authority in the evaluation process. The realistic evaluation approach creates a template for shared learning as to what works or doesn't work within specific contexts, with a rationale as to why.

The combination of these evaluative approaches will be complimented with a repeat of the baseline mixed methodologies at the end of the project to provide a pre and post data set for comparison.

The outcomes from both will also inform shared learning across multidisciplinary and multiagency boundaries as well as informing the development of integrated models of occupational therapy provision across Scotland.

Milestones Achieved

The SWITCH Partnership activity to date has achieved the implementation of four of the six key mechanisms for change:

- Shared Organisational Ethos and Service Priorities
- Unified Evidence Based Approach
- Single Shared Assessment (SSA) and Outcome Measurement
- Unified Approach to Operational Management

These implemented mechanisms provide the organisational context in which to deliver the outstanding mechanisms to achieve relational continuity of care for service users. The current implementation focus is on delivering the in-reach/outreach and extended duty of care practices within the East Kilbride and Hairmyres locality, with a particular emphasis on community based re-ablement service delivery. The evaluation approaches for continuous improvement will continue to be a central feature of the remaining implementation and evaluation phases. The project is due for completion July 2010.

Service Development Outcomes

The outcomes of the SWITCH partnership are comprehensive, reflecting the project's focus on informational, management and relational continuity of care to ultimately improve the service user experience of services across the whole system. Key outcome indicators include:

- 130 practitioners across acute, primary care and local authority routinely using a unified evidence based approach to practice
- 57 practitioners utilising a unified electronic evidence based Single Shared Assessment module for occupational therapy services across acute, primary care and local authority service within the NHS Hairmyres locality and South Lanarkshire Council.
- Reducing the number of therapists involved in a service user care episode, from an average of 3 to 1, providing one point of contact to achieve better coordination of care
- A reduction of duplicate activity associated with transitions of care by 60% to create workforce capacity to reinvest in person centred service developments
- A reduction in service wait time associated with transitions by 18 days from a potential whole system wait period of 56 days within the existing care pathway.
- A reduction in OT length of contact within the Acute phase from 49 days to 17 days.
- Determine service user outcomes in relation to wellbeing and independence from assessment to discharge (significance to be determined)
- A reduction in levels of homecare provision by 30% whilst maintaining service user levels of independence.

Conclusion

The SWITCH partnership has embraced a multi-faceted approach to change that will ultimately improve the patient /service user experience of occupational therapy services across Acute, Primary Care and Local authority services; whilst simultaneously creating significant organisational service efficiencies. The realisation of informational, management and relational continuity of care requires cultural, practice and system changes that are both complementary and cohesive, in efforts to create a sustainable outcome focused service model for practice. The intrinsic evaluation approaches (Action Research and Realistic Evaluation), systematically informs the practice and system service developments during implementation. These approaches create an understanding of what works and why it works in specific circumstances, providing a reference framework for health and social care service redesign.

Contact Details

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