Occupational Therapy in Adult Social Care in England

Sustaining a high quality workforce for the future

Working in partnership with the College of Occupational Therapists
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For Recipient’s Use
Occupational Therapy in Adult Social Care in England

*Sustaining a high quality workforce for the future*

**Authors:** Jill Riley, Steven Whitcombe and Chris Vincent, School of Healthcare Studies, Cardiff University

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Foreword

This report is the result of partnership working between the Department of Health and College of Occupational Therapists.

It identifies the opportunities and challenges facing the occupational therapy workforce in social care in transforming services to meet the needs of service users and carers, both now and in the future.

Occupational therapy is the largest Allied Health Professions group employed in social care. Occupational therapists will be key to enabling and supporting independence and maintaining health and well-being.

The occupational therapy workforce will be pivotal in leading service transformation, which will ensure service users have choice and control. 35% of local authority social services referrals are dealt with by occupational therapy staff (which represents 2% of the workforce), and the demand is likely to increase given the demographic changes particularly in relation to the number of older people.

This report is a useful tool to promote dialogue locally that will ensure the occupational therapy workforce in social care is taken into account in workforce planning. The report includes a number of examples of the ways in which occupational therapists in social care are recognising the importance of clinical practice placements, not only in relation to the education of the future workforce but also in relation to staff recruitment and retention.

This report proposes next steps that enable the occupational therapy workforce to contribute to creative and innovative solutions at individual, service, organisational, and systems levels to support service transformation and deliver sustainable outcomes for service users and carers.

We commend this report to you.

Chief Health Professions Officer, Department of Health

Chief Executive, College of Occupational Therapists
Executive summary

Background:

Occupational therapists contribute to the health and well-being of the population in promoting self-reliance and resourcefulness for service users and their carers. They have skills in complex problem-solving, prevention, enabling independence, environmental design and adaptation, and a person-centred approach to practice. These, together with their ability to work across health, social care, housing, education, employment, voluntary and the independent sector places them in a key position to contribute to the delivery of the modern, personalised and integrated adult social care services as outlined in Putting People First.

Occupational therapists assist people of all ages with physical, mental and social impairments and learning disabilities to achieve health and well-being by improving their ability to carry out the activities they need or choose to do in all aspects of their daily lives. In social care services occupational therapists work with both adults and children; they are the only members of the allied health professions¹ to be employed in these services in any numbers. In England, during the last decade, the numbers of occupational therapists in social care services as a whole have risen from 1,520 in 1998 to 1,880 in 2007 with on-going increases expected. Today 1,220 work in adult social care services where they make up approximately 2% of the workforce and yet they deal with approximately 35% of the referrals for adult social care services.

Occupational therapists are a relatively small but crucial part of the adult social care workforce. With their support staff, occupational therapists have the skills and competencies to contribute to the delivery of social care sector services and help in meeting statutory obligations. Historically however, there have been problems recruiting occupational therapists to adult social services departments in England; vacancy rates were amongst the highest in the adult social care sector in 2005-2006. There is a constant demand for occupational therapy assessments and services and this is likely to increase as a result of predicted demographic change.

The purpose of this report:

This report was commissioned in 2007 by the College of Occupational Therapists on behalf of the Department of Health in the light of the Options for Excellence workforce review² and a recognised need to build an occupational therapy social care workforce for the future by improving opportunities for student placements and supporting newly qualified staff. It outlines the key findings from an online survey and focus groups investigating workforce sustainability and practice development in adult social care occupational therapy services in England and aims to identify:

- Best practice in occupational therapy recruitment and retention within social care in England that will ensure a sustainable workforce for the future and meets the needs of the users it serves.

¹ ‘Allied Health Professions’ (AHPs) comprise a number of different professional groups regulated by the Health Professions Council (HPC) a list of allied health professions is provided in annex 1.
• Practice developments that demonstrate the cost benefit of occupational therapy interventions and the benefits of recruitment of occupational therapists into new roles within social care.

• The current provision and future need for occupational therapy student placements within social care in England, to ensure an equitable contribution to the supply of the national occupational therapy workforce.

Summary of the key messages:

As a consequence of demographic change, the number of older people and people living with complex and long-term needs will grow. Targeting occupational therapists’ skills will be crucial in assisting people to maintain independence and prevent dependency on health and social care services. Sustaining a flexible, high quality occupational therapy workforce that will meet the needs of modernised adult social care services requires full recognition of the benefits that occupational therapy services can bring to enabling and supporting service users’ independence and promoting choice as well as the cost benefits to the organisation.

Raising the profile of occupational therapy in adult social care and an ability to demonstrate the effectiveness of occupational therapy in creating long-term sustainable solutions to assist service-users in managing complex needs are a key part of sustaining a high quality occupational therapy workforce. Transforming the workforce in line with the Department of Health’s vision for social care services⁴ will require occupational therapists to diversify and continue developing new roles. The promotion of occupational therapy as a career in social care for potential and pre-registration students, and post graduates working in other sectors is crucial to the future of the workforce. Because practice placements strongly influence students’ choice of future practice, there must be sufficient opportunities for student placements in adult social care to attract them into this area of work. A career structure for occupational therapists in social care that supports multi-professional working, professional leadership and equal opportunities for progression into strategic management posts in adult social care service can in turn impact on recruitment and retention.

Summary of Recommendations and Next Steps:

A number of recommendations are made in Section five that focus on:

• Building on existing good practice and service improvements.
• Demonstrating the cost effectiveness of occupational therapy services.
• Sustaining a high quality workforce.
• Educating for the future workforce.
• Research.

The Department of Health, Directors of Social Care and the College of Occupational Therapists have committed to several next steps to take those recommendations forward:

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Next steps

The Department of Health commits to:

- continuing to recognise the important contribution that occupational therapists make to meeting the needs of people using health and social care services
- absorb the findings of this report as part of the development of the Department’s adult social care workforce strategy, which is being taken forward by its adult workforce strategy board.
- ensure that the need for an occupational therapy workforce is factored into workforce planning initiatives (covering both local authorities and the NHS) and the commissioning of education through the Strategic Health Authorities (SHAs).

Directors of Social Care commit to:

- work with the College of Occupational Therapists (COT) to develop mechanisms to share best practice in recruitment and retention to address local recruitment and retention issues
- create opportunities for diverse roles that maximise the contribution of occupational therapists
- be prepared to challenge those job opportunities that are advertised specifically for named professionals
- recognise the skills that occupational therapists can bring to strategic and joint planning forums that assist in meeting the local area agreements
- support and encourage practice placements for occupational therapy students
- enable leadership opportunity and resources for continuing professional development (CPD)
- ensure occupational therapy workforce needs are identified to inform future workforce planning
- include occupational therapists in local transformation developments where their contribution benefits service users and carers.

The College of Occupational Therapists commits to:

- providing resources to carry out a literature review of research that evidences the cost effectiveness of occupational therapy, future areas of practice and service user evaluation of occupational therapy services within social care
- continue to have a presence on the Social Care Workforce Board to support future development
- seek to develop, in collaboration with the General Social Care Council, career development opportunities for occupational therapists that are more comparable with opportunities available for social work colleagues
- promote best practice and expertise through the COT specialist sections
- seek opportunities to showcase the cost effectiveness of occupational therapy services and the impact on the lives of service users
- maximise opportunities within SCIE to evidence best occupational therapy practice
- work in partnership with Higher Education Institutions, social care providers and the Placement Tutors Forum to secure an increased placement provision for students
- work actively with occupational therapy social care managers to develop an appropriate skill mix for occupational therapy personnel
- work with social care managers to address the occupational therapy contribution to the personalisation agenda
- to develop a position statement for occupational therapists who primarily assess the needs of children and their families within the adult social care workforce
- develop leadership capacity in students, social care occupational therapy practitioners and managers of services to develop innovative and high quality workforce and services through entrepreneurial approaches
- work actively with the Association of Directors of Adult Social Services to promote occupational therapy and this report

**Occupational therapists and managers commit to:**

- proactively seek opportunities to create more diverse roles and develop their own careers within social care
- identify and nurture champions and develop talent by positioning occupational therapists in situations that enable them to grow
- networking, learning and sharing good practice
- challenge those job opportunities that are advertised for other named professions
- actively seek to develop the range and scope of practitioners able to offer occupational therapy services in order that professionally qualified occupational therapists manage increasingly complex cases and develop new areas of work
- actively identify ways to market occupational therapy solutions to policy imperatives
- identify workforce needs and ensure that these are communicated to SHAs for inclusion in commissioning decisions
- take personal responsibility for their own CPD in pursuance of their career development
- work with service user groups to influence and inform how future services need to develop
Section 1: Context

1.1: Introduction:

Occupational therapists work with service users and their carers to promote quality of life, health and well-being in a range of public, independent and voluntary sector settings including the National Health Service (NHS); local authority social services, education and housing\(^4\). Although the vast majority of occupational therapists are employed in the NHS (17,024 in 2007 representing 62% of occupational therapists registered in the UK)\(^5\), they have been part of social care services for children and adults since local authority departments were first set up. They remain the only allied health professionals to be employed in social services departments in any numbers\(^6\). During the last decade the total number of occupational therapists employed in social care services as a whole has risen from 1,520 in 1998 to 1,880 in 2007. Recent statistics indicate that in 2007, 160 occupational therapists were employed in children’s services, 500 were involved in generic provision and 1,220 (65%) were employed in adult social care services representing approximately 2% of the total adult social services staff group (not including children’s services or generic provision) 32% of whom are social workers\(^7\). It is important to note that in many local authorities occupational therapists employed in adult social care services also provide assessments and services for children.

Whilst occupational therapists remain a relatively small proportion of the adult social care workforce, there is a constant demand for occupational therapy assessments and services and this is likely to increase as a result of predicted demographic change. Historically occupational therapists have received a high proportion of the adult social services departments’ referrals\(^8\)\(^9\). Findings from social services inspection reports for the last 5 years and a recent benchmark report\(^10\) indicate that the demand for occupational therapy assessments and services remains increasingly high.

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\(^4\) College of Occupational Therapists (2008) Defining occupational therapy Available at: [www.cot.org.uk/members/promoting/defining_occupational_therapy.doc](http://www.cot.org.uk/members/promoting/defining_occupational_therapy.doc) accessed on 21/7/08


\(^8\) Mountain G (2000) Occupational Therapy in Social Services Departments, A review of the literature London: College of Occupational Therapists


1.2: **Occupational therapy in social care services:**

The philosophy of occupational therapy is founded on the concept of *occupation* as a key element of health and well-being. Practice in social care services embraces the social model of disability and is based on holistic and person-centred care, emphasising the promotion of self-reliance and resourcefulness\(^\text{11}\). Occupational therapists assist people of all ages with physical, mental and social impairments and learning disabilities to achieve health and well-being by improving their ability to carry out the activities they need or choose to do in their daily lives\(^\text{12}\). They work with people who have complex problems or minor coping difficulties and those who are functioning well and wish to maintain independence\(^\text{13}\).

Occupational therapists have skills in problem solving, enablement, prevention and environmental adaptation that can be used in a variety of ways to support the delivery of the modern personalised and integrated adult social care services outlined in *Putting People First*\(^\text{14}\). There is evidence to suggest that service users are generally satisfied with the services that occupational therapists provide\(^\text{15}\). In the light of a predicted increase in numbers of older people and people with complex long-term needs, their skills will remain crucial in assisting people to maintain independence, promote health and well-being and prevent dependency on health and social care services and thereby reduce the financial burden on local and national government expenditure.

1.3: **Occupational Therapy as a profession:**

Occupational therapists as members of the Allied Health Professions are regulated by the UK Health Professions Council (HPC). All practicing occupational therapists are required to register with the HPC and must adhere to a professional code of ethics and conduct. The HPC sets standards for continuing professional development (CPD) as a requirement of registration to ensure that therapists continue to learn and develop throughout their careers and keep knowledge and skills up to date in order to practice safely, legally and efficiently\(^\text{16}\). In 2006, the College of Occupational Therapists introduced a post-qualifying framework to assist

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\(^{11}\) College of Occupational Therapists (2008) *COT position statement: the value of occupational therapy and its contribution to adult social service users and their carers* London: College of Occupational Therapists

\(^{12}\) College of Occupational Therapists (2008) *Defining occupational therapy* Available at: [www.cot.org.uk/members/promoting/defining_occupational_therapy.doc](http://www.cot.org.uk/members/promoting/defining_occupational_therapy.doc) accessed on 21/7/08

\(^{13}\) Creek J (2003) *Occupational therapy defined as a complex intervention*. London: College of Occupational Therapists


\(^{15}\) Skelton J (2006) *Through critical appraisal determine the themes and outcomes form best value reviews of occupational therapy services within the social care setting in England and their usefulness* London Metropolitan University (unpublished MSc dissertation)

\(^{16}\) Health Professions Council (2008) *Standards of conduct, performance and ethics* London: Policy and Standards department, Health Professions Council
occupational therapists in planning CPD activity and career development and to ensure and enable compliance with the requirements of continued registration.

1.4: Pre-registration education:

Occupational therapy students are eligible for initial HPC registration following successful completion of a pre-registration BSc honours degree, post-graduate diploma or Master's degree in occupational therapy. The majority of student places on pre-registration programmes are funded by a Department of Health NHS student bursary. Programmes combine academic and practice-based study. Approximately one third (equivalent to 1000 hours) of the programme is spent on practice placement, where students gain work place experience of occupational therapy practice in a range of organisational settings including local authority social services and integrated health and social care services.

1.5: The organisational and policy context:

Like all health and social care professionals, occupational therapists work in an environment that is determined by the legislative framework. In the case of occupational therapists working for local authorities that framework is further informed and defined by the specific duties required of their local authority in respect of community care, health and safety at work and housing legislation. Occupational therapists also work within a policy framework which the Department of Health defines and informs through guidance for delivering a social care system that provides care equally for all, whilst enabling people to retain their independence, control and dignity.

Occupational therapy services are based on individual need and focus on improving and maintaining service-users’ independence and preventing dependency. However, occupational therapists have been employed by local authorities primarily to meet specific legislative requirements, often ignoring their potential to contribute to the broader social care agenda. Occupational therapists’ work is driven by duties under the Chronically Sick and Disabled Persons Act 1970, pertaining to making arrangements in relation to practical assistance including adaptations and additional facilities (equipment). Occupational therapists also assess and make recommendations for Disabled Facilities Grants (DFGs) under the Housing Grants, Construction and Regeneration Act 1996 where there is a duty to consult the local authority. The growing trend for detailed advice on moving and handling situations means that occupational therapists also require a good understanding of Health and Safety legislation. Consequently, the majority of occupational therapy services focus on people’s self-care needs. However, occupational therapists’ knowledge and skills in enabling service users’ to address their work and leisure needs and aspirations could significantly contribute to the Putting People First agenda by promoting active citizenship.

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Additionally, because many adult social care services employ occupational therapists who continue to assess the needs of children, awareness of legislation relating to children is an important but often not recognised key element of the occupational therapy role.

1.6: Inter-disciplinary working and service integration:

Occupational therapists in social care services have a strong history of inter-disciplinary working and working across sector boundaries\(^{20}\). In order to enable service users with complex health, social and environmental needs to live in a safe, accessible environment that is, as far as possible, compatible with their chosen lifestyle\(^{21}\) occupational therapists work closely with social workers, social care administrators and support workers. They also work in partnership with colleagues in health, housing and the voluntary sector. Occupational therapists’ skills in inter-disciplinary and inter-agency working place them in a good position to move forward with the Government’s agenda for service integration\(^{22}\). In several areas of England, occupational therapy social care services are now integrated with health and in some instances with other public sector departments e.g. housing. Research into social services occupational therapists’ views of integration with health suggest that occupational therapists welcome the concept of integrated services that will allow them more time to spend with service users and expand their roles for example to promote independence via rehabilitation/enablement\(^{23}\).

The following examples illustrate two integrated occupational therapy services:

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\(^{20}\) Riley J (1999) *The integration of occupational therapists into the new social services: a dilemma for the profession* Cardiff: University of Wales College of Medicine (unpublished MSc dissertation)


\(^{22}\) Department of Health (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care* London: Department of Health

Example 1: developing an integrated health and social care occupational therapy service in southwest England:

Over the last 8 years, occupational therapists and their managers from the PCT and local authority adult social services have worked in partnership to develop an integrated occupational therapy service. Following detailed project planning, costing and the formation of a project board with key PCT and local authority representation, integration has been achieved through:

- co-location of 7 PCT and 18 local authority OT staff to a single base
- a single referral pathway for all PCT and local authority community OT referrals
- development of a joint information system
- a single assessment process
- an integrated OT management team
- integrated CPD peer support groups
- two rotational OT posts into the service
- an integrated approach to budget management
- the development of flexible/mobile working

Example 2: an integrated health, housing and social care occupational therapy service in northwest England:

An integrated occupational therapy service has developed across three public sectors to include:

- a community occupational therapy equipment service
- telecare, telehealth and assistive technology
- a wheelchair service
- a major adaptations service
- sensory services and social work for people with physical disabilities are based with the occupational therapy service.

Service users benefit from a person centred approach, improved efficiency and performance, a single point of contact and an occupational therapy team that are trained to assess and deliver the full range of services.
1.7: The role of occupational therapists in social care services:

Traditionally the role of occupational therapists working in local authorities has been shaped by statutory legislation to focus on the assessment and provision of equipment and adaptations for disabled and vulnerable people\textsuperscript{24, 25}. The assessment for and provision of equipment and adaptations continues to be an important aspect of occupational therapists’ work, in that its timely provision can improve quality of life, enable independence and prevent dependency\textsuperscript{26}. There is also evidence that equipment and adaptations can be cost effective by enabling savings in the cost of formal care\textsuperscript{27, 28}. Occupational therapists are now extending and developing their roles for example:

- in local authority housing departments where their expertise not only benefits service users, but can contribute to building design, strategic planning and housing policy\textsuperscript{29}
- in reablement and rehabilitation where occupational therapists’ skills in designing interventions that enable service users to gain independence in daily living activities can be used as a part of an outcome focused programme. Occupational therapists also assist other staff e.g. support workers and home carers in gaining the skills they need to assist service users in re-learning daily living skills\textsuperscript{30, 31}.

\textsuperscript{24} Mountain G (2000) Occupational therapy in social services departments, A review of the literature London: College of Occupational Therapists


• in telecare, telehealth and assistive technology where occupational therapists can use their skills to assess for appropriate technology and facilitate its use to maximise the potential for the service user to maintain their independence.\textsuperscript{32, 33}

• in employment and vocational rehabilitation to assist people with disabilities to enter the employment market

• in the design and shaping of community developments such as access to mainstream services, planning and regeneration of community areas

1.8: Recruitment and retention:

Historically there have been problems recruiting occupational therapists to adult social services departments in England; 47\% of authorities reported difficulties in 2005 – 2006 and vacancy rates were the second highest in this sector. A 10.3\% vacancy rate was established by the adults’ social care workforce survey 2006\textsuperscript{34}; this was linked to a lack of applicants with relevant experience, competition from other statutory sectors and unattractive pay. In addition, the public’s perception of working in social care, a lack of career advice and high caseloads may also have an effect\textsuperscript{35}. The promotion of occupational therapy as a career in social care, together with the limited number of placements available for occupational therapy students impacts on the future development of the occupational therapy workforce in this area.

The following example illustrates how a health and social care community\textsuperscript{36} in the north of England has developed a practice placement co-ordinator post to ensure that occupational therapy students have a high quality placement and gain experience in a range of social care services. Evidence from applications for occupational therapy posts in this community has identified that high quality student placements positively impacts on recruitment:

\textsuperscript{32} College of Occupational Therapists (2007) Occupational Therapists as facilitators of telecare COT/BAOT Briefings 84 London: College of Occupational Therapists


\textsuperscript{34} Local Authority Workforce Intelligence Group (2007) Adults’ Social Care Workforce Survey 2006 London: Local Government Analysis and Research


\textsuperscript{36} The health and social care community comprises a NHS Mental Health Foundation Trust, NHS Hospital Foundation Trust, NHS Community Health Services & Local Authority Adult Services
Good practice in recruitment and retention:

“A practice placement coordinator role in a health & social care community”

Applications for occupational therapy posts in this health & social care community indicate that past occupational therapy students want to work in these services post-qualification.

To ensure high quality student placements the occupational therapy services in this health and social care community share a practice placement coordinator who is responsible for coordinating & organising the whole range of practice placement education, redeployment of students & mentorship of practice placement educators.

The Practice Placement Coordinator:

- reports to the respective lead occupational therapists on all issues relating to practice placement education (PPE)
- produces an annual report on PPE and mentorship which can be used to inform relevant Trust and Local Authority senior managers/directors
- maintains effective links with higher education institution (HEI) practice placement tutors
- monitors accredited and developing practice placement educators and encourages staff to complete training for APPLE accreditation
- keeps practice placement educators and mentors up-to-date with information relating to PPE
- maintains a database of practice placement educators – recording the number and length of placements they have provided each academic year
- requests and collates offers for practice placements
- arranges and facilitates support groups for all students
- monitors the effectiveness of the tutorials based on student and tutor feedback
- collates student evaluation
- promote networking and support, disseminate relevant information and to identify any unmet training needs
- actively seeks ways to increase the range and quality of practice placement education

The Practice Placement Coordinator role is highly valued by the respective organisations, the HEIs, occupational therapists & students. The reputation gained for providing high quality student placements through excellent support & supervision structures both pre & post qualification has proved to support recruitment & retention within the OT services. The role has also provided a good CPD opportunity for occupational therapists within the services.
Section 2: Methods

Data were gathered during March and April 2008 through an online survey of all occupational therapy managers and occupational therapists working in adult social care services in local authorities and all higher education institutions (HEIs) delivering pre-registration occupational therapy programmes in England. Following the survey, two online focus groups were conducted with occupational therapy practice placement educators and newly qualified occupational therapists working in adult social care services. In addition, the research team worked closely with a project steering group, who monitored progress and reference group who advised on issues relating to occupational therapy in adult social care services.

A list of the project objectives can be found in annex 2 and full details of the methods of data collection and analysis in annex 3.
Section 3: Research findings

The following sections detail the key messages from the research findings. Full details of the findings, statistical tables and graphs can be found in annex 4.

3.1: Authorities and service provision:

A total of 121 authorities were represented in the survey (see annex 3 p. 39), which were evenly spread geographically across England. Authorities included county, unitary, city, borough and metropolitan borough councils and the London boroughs. In 52% of these authorities occupational therapy social care services were provided by social services only; 29% of services were provided by social services and the PCT i.e. integrated services and 19% by the PCT alone (table 1 p. 42).

3.2: Occupational therapy referral rates:

Although occupational therapists make up only 2% of the adult social care workforce, in a six month period between April and September 2007 they received on average just over a third (34.7%) of their department’s referrals for adult social care services (figure 1 p. 43).

3.3: The occupational therapy social care workforce:

The demographic profiles of respondents indicate that the majority of occupational therapists working in social care services are female (89%), white (92%), non-disabled (97%) and aged between 25 and 49 years (73%). A significant percentage of these occupational therapists (60.5%) were over 40 years of age and just over a quarter (26%) were over 50 (figure 2 p. 43 details ethnicity and table 2 p. 44 respondents’ age range). In terms of demographics, the sample from the survey as a whole was representative of the occupational therapy workforce in adult social care services when compared with data collected by the Information centre for health and social care.

Although the majority of occupational therapists qualified more than 5 years ago the length of time since qualifying ranged from 4 months to 39 years, indicating the breadth of experience in the workforce as a whole (figure 3 p. 44).

3.4: Recruitment and retention:

Twenty seven authorities indicated that they were experiencing difficulty recruiting qualified occupational therapy staff in 2007. In line with the 2006 Adult Social Care Workforce survey, these authorities were in London and its conurbation; the North West of England; one or two larger cities and rural areas. In 70% of cases occupational therapy social care services were provided exclusively by the local authority.


The main problems with recruitment and retention were because of high living costs in particular areas; lower pay structures for occupational therapists in local authorities than in neighbouring Trusts and difficulties in recruiting experienced staff to senior posts. However, respondents cited good recruitment and retention packages; an established team with a good reputation; strong CPD programmes and a good supply of new graduates coming out of universities into the profession as contributing to successful recruitment and retention.

3.4.1: Vacancies and frozen posts:

Forty seven percent of responding authorities had vacancies for occupational therapists in 2007-08 (figure 4 & 5 p. 45), mainly due to organisational changes, newly created posts and natural movement of staff. Eighteen percent of responding authorities had frozen occupational therapy posts in the same period. However, most authorities appear to have robust vacancy management strategies and examine the need for an appointment when any vacancy arises.

The majority of occupational therapy managers (63%) indicated that they had employed newly qualified staff during the year between April 2007 and April 2008. This could account for why there appears to be little difficulty with occupational therapy recruitment despite reported vacancies. Additionally, focus group participants indicated that having students on placement was a positive way of attracting potential occupational therapists to adult social care and an excellent advert for encouraging students to apply for work in their authority.

The following example illustrates one authority’s strategy for managing occupational therapy recruitment and retention:

In response to high vacancy rates, one authority has developed a seconded post to initiate an ongoing programme for support staff to qualify as occupational therapists through secondment to part-time four year pre-registration occupational therapy programmes in local universities. Ten staff are now qualified and are working in social care services and more are expected to graduate during the next few years.

3.4.2: Changes to posts:

Thirty nine percent of authorities had made changes to occupational therapy posts since April 2007. Changes were mainly due to management restructuring and a creative use of budgets to increase numbers of staff and improve the skill mix or target particular specialist roles.
3.5: Occupational therapy roles:

The most common roles undertaken by occupational therapists in adult social care services relate to the assessment for and recommendation of equipment, adaptations and disabled facilities grants (table 3 p.47) and are largely concentrated around their local authority’s legislative duty. There is little indication as yet of the impact of the government’s agenda for transforming equipment services[^39], which may reduce the need for occupational therapists to assess for low priority/less complex need for community equipment, which forms a small part of the comprehensive needs assessment for service users.

Occupational therapists also have strong roles in risk assessment, which are commonly related to problems with moving and handling, and in assessing housing needs. Occupational therapists are also involved in implementing rehabilitation/reablement programmes, checking and reviewing service provision and care packages. A small, but significant proportion of occupational therapists (8%) are now concerned with return to work initiatives in line with the government’s agenda for health and work in Britain[^40]. Other roles (not listed in table 3) included student supervision, team management, telecare assessments and blue badge appeals related work.

3.5.1: Role complexity:

Although support workers appear to undertake a similar range of roles to qualified staff in adult social care, the degree of similarity was tempered by the level of complexity. Support workers are also supervised by experienced occupational therapists who assist them with their decision making. With support and supervision newly qualified staff carry out similar roles to their more experienced colleagues however, senior staff tend to deal with more complex cases, have more responsibility for the supervision of other staff and take the lead in specialist areas. For example, more experienced occupational therapists work with service users who have multiple physical, psychological, social needs and environmental challenges that require specialist knowledge and highly developed clinical reasoning skills.

Whilst the assessment for and provision of equipment and adaptations feature strongly as a part of occupational therapists and support worker roles, its timely provision can make a difference to a service user’s dignity and independence. It can also reduce the need for a complex package of care as the following example from an occupational therapist’s case load illustrates:

[^39]: Department of Health, care services efficiency delivery (2008) Transforming community equipment services. Available at: [www.csed-csip.org.uk](http://www.csed-csip.org.uk) accessed on 1/2/08

Mick is 58 year old man who has cerebral palsy. He has visual and speech impairments and shoulder pain following several falls. Mick has a complex range of functional needs resulting in difficulties with all aspects of personal care and daily living. Because of his mobility problems he uses a powered wheelchair; he needs assistance to sit up in bed and cannot transfer on and off the toilet or bed without a great deal of help.

Mick has a ‘live in’ carer (Rob) who stays with him on a week on/week off basis. Agency carers support Mick in Rob’s absence. Mick was referred to an occupational therapist because his transfer and toileting problems were increasing, placing him and his carers at risk. Rob felt that he was lifting and or/ supporting Mick more than was safe for both of them. Following an assessment, the occupational therapist was able to provide:

- A portable hoist and sling to lift Mick onto the bed – this required 2 carers to eliminate risk to health and safety
- A special bed and mattress to ease Mick’s discomfort and enable the carers to transfer him safely.
- An alternative commode chair and urinals for use during day and night to limit the number of transfers required.
- A portable intercom system so Mick could communicate with his carer during the night if there is a problem

Following a case review of the lifting and handling and hygiene problems, the occupational therapist recommended the installation of a powered hoist which could be operated by one carer and an automatic flush/wash/drying toilet. This gave Mick more choice over his bedtime and greater control and dignity in terms of his personal care.

The roles of the occupational therapists in adult social care are complicated further by the need to work within localised service priority criteria and national targets. The following case example illustrates the complexity of occupational therapy assessment and intervention, where clinical reasoning skills are required to offer a long term solution that takes into account service user’s complex needs, personal choice, cost effectiveness and organisational priorities:
Mr and Mrs Brown are in their early fifties and live in a 2 bedroom council house. Mrs Brown weighs over 20 stone and has multiple health problems. She is dependent on a powered wheelchair for mobility and her movement around the property is severely restricted because of the size of her wheelchair. She can only move between the living room and kitchen, consequently she and her husband sleep in the living room where all of Mrs Brown’s personal care takes place. She can only leave the property via the back door. If Mrs Brown falls she calls firemen from a neighbouring station for assistance. She is a high priority in terms of eligibility for services.

Mr Brown is his wife’s sole carer, he has one day off each week when she attends a day centre. He has been offered respite care but will not leave the house because of the risk of vandalism or burglary.

Adaptations have been made to the property in the past, including widening doorways and converting the ground floor toilet into a shower room. Because of Mrs Brown’s increasing problems, she is no longer able to use these facilities. Re-housing options have also been explored with the OT, but found to be unsuitable.

Following a series of assessments and through liaison with other agencies including health, housing and senior colleagues, the occupational therapist proposed a number of potential options for Mr and Mrs Brown:

- a through floor lift to the 1st floor and conversion of the existing rooms within the property to allow space for a larger level access shower room, separate bedroom and living space
- an extension to the rear of the property to locate all facilities on the ground floor
- relocate Mr and Mrs Brown to an already adapted bungalow

The final solution to Mr and Mrs Brown’s problems must take into account their current and long term needs, choice, cost effectiveness and organisational priorities. Although relocation is the cheapest option, it would involve Mr and Mrs Brown moving away from their community and is not their preferred choice. In this instance, adaptation to the existing property is the most likely course of action.
3.5.2: **Innovative/expanded roles:**

Occupational therapists said that their role could be expanded to improve the local authority service and outcomes for service users. They identified that there was a clear need to build on roles relating to rehabilitation/reablement; return to work initiatives; health promotion, preventative work and working with housing and planning authorities to implement *Decent Homes* programmes\(^{41}\), design inclusive accommodation and influence wider community access. For example:

<table>
<thead>
<tr>
<th>Occupational therapists working in housing (southwest England):</th>
</tr>
</thead>
<tbody>
<tr>
<td>One authority has 5 (wte) occupational therapists dedicated to working in housing. These occupational therapists:</td>
</tr>
<tr>
<td>• take referrals relating to housing issues</td>
</tr>
<tr>
<td>• are involved in district councils’ housing development work</td>
</tr>
<tr>
<td>• are involved in the development of housing association’s strategies</td>
</tr>
<tr>
<td>• work with architects from early planning stage on purpose-built housing schemes and refurbishments</td>
</tr>
<tr>
<td>• incorporate tenant’s housing needs into plans</td>
</tr>
<tr>
<td>• are involved in housing allocation panels for people with specific medical needs</td>
</tr>
</tbody>
</table>

In addition, occupational therapists have successfully recommended that landlords build new properties, or buy and adapt properties for specific tenants with disabilities where there are no suitable properties available within the existing local housing stock.

The authority has an active Extra-Care Housing development programme in various locations across the county. An occupational therapy advisor is involved at a strategic level in programme development and advises local schemes during the planning, developing and housing allocation stages.

These initiatives have meant that spending is more informed and focused resulting in value for money, less need for subsequent adaptations, less disruption for tenants and better planned housing schemes.

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Further examples of innovation relate to creating effective working practices including:

- the use of tablet technology to enable service users to make informed choices about their services and increase efficiency in recording
- streamlining assessments through the use of mobile clinics to empower service users, increase access to services and ensure that people are seen quickly in their own locality
- fast tracking of assessments via the use of telephone or self assessment as a means of dealing with straightforward/low level needs
- the use of ‘hot desking’ and electronic record systems to streamline working arrangements

The following example from an authority in the south of England illustrates how the use of information technology and mobile working can improve working efficiency for occupational therapists and streamline service provision:

**Changing the way occupational therapists work:**

Issuing every OT with a tablet PC has enabled them to work away from base:
- information on allocated cases is stored on a shared drive
- each OT has an assessment co-ordinator (administrator) who organises visits, inputs assessments and care plans, generates letters, orders and monitors equipment and adaptation work, enabling the OT to focus their time and skills for the benefit of service users
- assessment can be completed electronically whilst with the service user

Future developments will include:

- implementing the electronic social care record and interfacing it with assessments and care plans
- interfacing the system with the web-based electronic equipment ordering system (through ICES), enabling service users to view equipment whilst the order is being placed
- implementing adaptations software to allow plans and drawings to be shared electronically

### 3.6: Cost benefits:

Ninety percent of managers in the responding authorities believed that their service was cost effective. Maintaining service users within their own home for as long as possible by early occupational therapy intervention, reducing care packages and preventing dependency on other services were considered to be the main cost benefit of occupational therapy services. As one occupational therapist put it:
“The local authority is developing models which ensure that all service users go through a period of enablement / rehabilitation prior to identifying their ongoing support needs. Our enablement service has shown consistently that following OT intervention there is an average of £2,500 saving per user per annum in community care funding”

The following case example illustrates the cost benefit of occupational therapy as part of an enablement service:

<table>
<thead>
<tr>
<th>Case Example for Cost Benefit of Occupational Therapy</th>
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</table>
| John is 78 years old and lives with his wife in their own home. John had a stroke in 2006, resulting in a weakness of the right side of his body and admission to hospital. Before the stroke, John was fully independent and he and his wife were active members of the local community. Following discharge from hospital John required help with all aspects of personal care; he needed a hoist to move him from his bed to the wheelchair. John was looked after by 2 carers who visited him 3 times a day. John began to improve slowly and was referred to an enablement team by a social services occupational therapist who felt he had good motivation and potential for rehabilitation. John was seen by the occupational therapist from the enablement team who:

- assessed John’s personal care abilities and level of mobility
- observed how the carers were helping John
- provided appropriate equipment to enable his independence
- set up a programme with John so that he could work towards independence in personal care with supervision
- made alterations to the care package so that one carer was supervising John’s personal care
- monitored John’s progress

Following the enablement programme John can manage his personal care independently or with minimal supervision from his wife, he has been able to cancel the care package and return most of the equipment issued.

The cost benefit to the service following enablement was £271 per week (£14,109 per year). The total saving on equipment was £3105
Further examples of cost effectiveness include:

- the use of an effective initial assessment team that is able to identify need and direct clients immediately to the appropriate service
- the use of occupational therapy assistants and support workers to complement the work of specialist qualified occupational therapists
- the use of ‘drop in’ clinics, where service users can come to a local centre in line with the government’s agenda for delivering care closer to home.

3.7: Contributions to workforce sustainability:

Evidence from the questionnaires identified that there were opportunities for supervision and CPD for occupational therapists in adult social care services. However, focus group discussions indicated that effective supervision and opportunities for education and training both at pre-registration and post-graduate level could be a contributory factor in sustaining the occupational therapy workforce in this area.

3.7.1: Supervision:

The purpose and use of supervision for occupational therapists in adult social care varies depending on the level of experience. Accordingly, newer members of staff value regular and frequent supervision where they could discuss issues relating to organisational working practices. Supervision of new staff also serves as a forum for building on new practitioners’ knowledge of the more common problems/conditions encountered by service users in adult social care. In contrast, as new practitioners gain experience, supervision is a useful way to focus on particular issues relating to individual cases and further develop clinical reasoning skills.

3.7.2: Supporting newly qualified occupational therapy staff:

Respondents from the focus groups of recently qualified staff said that in addition to supervision and peer support a formalised induction process is important for gaining “a good grounding” into the organisational culture of social services. A previous practice placement experience in social services is helpful in this respect but was not seen as a pre-requisite for working in a social service setting.

3.7.3: Education, qualifications and training:

Half of the occupational therapists said that they had undertaken a post-registration course in their current employment. Courses included training in skills relating to the occupational therapy role; management/administrative training; postgraduate qualifications and practice placement educator courses.

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Additionally, 72% of managers said they provided sponsorship/secondment schemes to enable support staff to qualify as occupational therapists. Employers are also encouraging support workers to undertake a qualification in health or social care and/or an accredited award such as the National/Scottish Vocational Qualification at Level III in a related subject\(^{43}\).

### 3.8: Career structures and career limitations:

Sixty percent of respondents indicated that there was a recognised career structure within their department. Career progression was competency driven and at salient points in the pathway occupational therapists would be expected to prove their competency by application, interview, portfolio and/or appraisal.

There were indications from questionnaire responses and focus group comments that opportunities to move into specialist/supervisory/managerial roles were limited due to a lack of senior and strategic posts. Progression into strategic management was considered possible, but less clearly defined and respondents felt that promotion would involve more generic working, less use of occupational therapy skills and less contact with service users. There was also the feeling that the lack of remuneration and recognition for additional responsibility was a barrier to many occupational therapists applying for promotion. There is clearly a need in some authorities for succession planning and preparing staff to take on more senior roles and responsibilities; this is particularly important when taking into account that a high proportion of the workforce are now over the age of 40 (table 2 p. 44).

Additionally focus group participants indicated that there were difficulties in moving out of social services, restricting movement between health and social care sectors. The College of Occupational Therapists’ interactive learning opportunities programme \(^{44}\) and the recently launched modernising AHP professions career framework for allied health professionals may assist occupational therapists in planning career development and identifying transferable skills \(^{45}\).

### 3.9: The promotion of occupational therapy as a career in social care:

Practice placement strongly influences occupational therapy students’ choice of future work areas. It is also the most influential site for the development of professional concepts, attitudes and behaviours\(^{46}\). Participants in the practice placement educators’ focus group reported that their role as supervisor of occupational therapy students contributed to the promotion of the profession and as a means of attracting future graduates into adult social care.

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Communicating the complexity of occupational therapy provision across social services was seen as something which could be achieved by greater interdisciplinary working and more use of practices such as the shared supervision of students between professionals.

Additionally, where there are occupational therapists in management positions it is possible to raise the profile of occupational therapy both within and outside social care services e.g. through meetings with other agencies, organisations and higher education institutions. An occupational therapy manager from one authority felt that having a professional lead within an authority can work well for both the organisation and the profession. It allows for issues relating to occupational therapy to be dealt with appropriately and assists in raising the profile of the profession in social care services so that occupational therapists are attracted to apply for vacant posts.

3.10: The current provision of student placements in social care settings:

Nearly all occupational therapy pre-registration courses in England (92%) receive offers for placements in social services and the majority of occupational therapists (67%) stated that they provide practice placements for occupational therapy students, although the survey did not address the regularity of placement provision. Interestingly more placements are provided by occupational therapists who have completed a practice placement educator’s course within the last five years (table 4 p.51).

3.11: Models of student supervision:

In general, participants in the practice placement educator’s focus group favoured a more traditional one-to-one model of student supervision and were less familiar with other models such as long-arm and shared supervision. Participants indicated that regular ‘face to face’ contact between an educator and student was an essential element of the supervisory relationship.

Twenty eight percent of the HEIs surveyed said they offer long-arm supervision for occupational therapy students in adult social care settings i.e. when supervision is provided by an educator from outside the department where the placement takes place. Whilst focus group participants had no direct experience of long-arm supervision, they generally welcomed models of shared supervision especially where students are jointly supervised amongst occupational therapy practitioners. However, joint supervision with fellow practitioners tended to be seen as most beneficial for the supervisors e.g. for peer support rather than for the students themselves. Participants were more cautious with regard to interdisciplinary supervision fearing that this can compromise the development of occupational therapy students’ professional skills.

Long arm and shared supervision arrangements are not new, but participants’ reservations to engage with these models may be due to a misunderstanding their purpose and value. This reflects the findings from a 2002 study into occupational therapists’


interpretation of innovative supervision arrangements\textsuperscript{50}. However, there are clear benefits to adopting less traditional (one to one) models of supervision where support is provided. For example, the COT guidance\textsuperscript{51} on progressive supervision formats suggests that sharing students and taking more than one student at a time allows them to support each other, learn from each other and share professional ideas and knowledge.

3.12: The benefits and barriers to taking students on placement:

The benefits from taking students on placement were very much a four way process with advantages for the student, the therapist, the local authority within which the students were placed and the HEI.

For students, as one focus group respondent put it:

“By providing a good professional placement I feel we introduce students to best practice and provide them with lots of opportunities to try out their theory in a supportive environment. There is nothing like a dose of reality to put all their learning into perspective. We have a lot of staff with years of experience in what they do which I hope is inspiring for students. We also hope to build their confidence before they start work. As a result of this they seem to enjoy being here and we hope they go back to college and tell their friends!”

As a consequence of educating students, occupational therapists had opportunities to:

- reflect on their practice
- develop clinical reasoning when explaining their decisions and working methods to students
- keep abreast of current academic thinking on good practice
- contribute to their continuing professional development

For the social care sector, student placements:

- raised the profile of adult social care within the occupational therapy student population
- encouraged potential recruitment into social care and to the individual authorities where placements took place

For the HEIs it:

- created a two way dialogue between the university and practice
- ensures that practice informs teaching

The benefits of student placements listed above also have the potential to improve service users’ experience of social care services, for example through refining and developing therapists’ skills, improving interventions and contributing to the future recruitment of


occupational therapists into the service. Although the majority of respondents recognised the benefits, 76% also indicated that there were issues and challenges to accepting students on placement.

The main issues that caused concern for the practice placement educators were associated with:

- pressures of work in an environment where there is a high demand for services
- the lack of time available to support students
- the little or no financial reward and appreciation received for supervising a student
- the organisational culture and constantly changing working practices
- the additional administration required by universities

These issues were reflected in an earlier study into student placements in social services where occupational therapists’ resistance to offering student placements was related to what they perceived as additional work pressures. Emphasis was squarely placed on the pressures experienced from the demand for services and the political nature of social care services\(^\text{52}\).

In this study, the participants in the practice placement educators’ focus group suggested that longer placements, preferably with final year students might be a solution to occupational therapy educators’ need to balance work pressures and the responsibilities of student supervision. Although lengthening placement periods is contrary to suggestions documented in occupational therapy literature\(^\text{53}\) this may be a viable option for the provision of student placements in social care services, especially when coupled with more progressive supervision models and the provision of joint placements across health and social care sectors where students will gain from opportunities to follow service-user’s care pathways.


Section 4: **Conclusion and Recommendations**

4.1: **Conclusion:**

Sustaining a high quality and flexible occupational therapy workforce that can contribute to modernised adult social care services and support increasing numbers of people with complex long-term needs requires full recognition of the benefits that occupational therapists can bring to enabling and maintaining service users’ independence, facilitating choice and assisting people to meet their aspirations. Demonstrating the effectiveness of occupational therapy in creating long-term solutions to assist service-users in managing their own needs is a key part of sustaining a high quality occupational therapy workforce. A good career structure for occupational therapists in adult social care with a professional lead and equal opportunities for occupational therapists to progress into strategic management posts can positively impact on recruitment and retention. Sustaining a high quality workforce for the future requires occupational therapists in social care services to diversify, create and develop new roles and provide sufficient high quality student placements to attract new graduates into this area of work.

4.2: **Recommendations:**

**Building on existing good practice and service improvements:**

- Through a broader recognition by senior managers and professional occupational therapy leads of the contribution that occupational therapists and their support staff can make to social care services and the health and well-being of the population by enabling independence, promoting self-reliance and a person-centred approach to addressing service users’ needs and aspirations.

- By occupational therapists and managers being proactive in developing models of service delivery that take full account of occupational therapy staffs’ skill mix, professional expertise and ability to work across organisational sectors.

- There needs to be comparable career structures for occupational therapists and social workers within social care and integrated services with equal opportunities for career progression plus opportunities for leadership roles at a strategic level.

- By developing occupational therapists’ skills and expertise through opportunities for professional development and training through joint working using the General Social Care Council post-qualifying awards[^54], taking into account the College of Occupational Therapists’ post-qualifying framework and the competency-based framework for allied health professionals.

Demonstrating the cost effectiveness of occupational therapy services:

- Occupational therapists need to demonstrate the cost effectiveness of their services taking into account commissioners, service users and the contribution that occupational therapists make across organisational sectors e.g. social services, housing and health.

- By evidencing the effectiveness of occupational therapy services and the barriers to effective service delivery e.g. through the use of outcome measures, collecting data that evidences cost-effectiveness, referral rates and waiting times.

- By developing mechanisms within organisations for efficiently managing and screening occupational therapy referrals to enable occupational therapists to deliver effective and timely services.

- By fully recognising and promoting the value of the range of services that occupational therapists can offer to enable service users’ independence, promote health and well-being and prevent dependency; including the provision of equipment, housing adaptations, rehabilitation and reablement, vocational rehabilitation and prevention.

- Through developing and sharing models of service delivery that promote service user independence and choice and save money in other areas of the organisation e.g. inclusive housing design and adaptation, rehabilitation and reablement.

Sustaining a high quality workforce:

- Evidencing the extent to which occupational therapists working in adult social care services provide services for children and the impact this has on the delivery of services to both children and adults.

- By developing organisational strategies for tackling recruitment and retention in specific areas where this is a problem i.e. inner cities, London Boroughs and rural areas.

- Through investing in the future social care workforce by providing student bursaries that take account of the future need for occupational therapists in social care as well as healthcare settings and the Department of Health taking into account workforce needs for occupational therapists in this sector.

- By working with Higher Education Intuitions (HEIs) to increase the numbers of occupational therapy student placements in social care services and developing strategies to encourage more newly qualified occupational therapists to work in this area.

- By encouraging better use of models of supervision that take into account the needs of different staff, including newly qualified staff, students and the organisation in addition to professional responsibility for continuing professional development (CPD).

- By developing service models that can allow for movement across health and social care services to enable newly qualified staff to gain a breadth of experience e.g. through rotational posts.
Educating for the future workforce:

- Higher education institutions need to promote the advantages of long arm supervision and shared supervision more widely amongst social service practitioners.

- Occupational therapists need to be open to alternative models that have the potential to improve the student learning experience and lead to more student placement opportunities.

- By developing role emerging placements that raise an awareness of the potential for new occupational therapy roles in the social care sector e.g. in housing, voluntary and charitable organisations.

- Higher education institutions and social care placement providers need to continue their collaborative approach, as the educational needs of students in order to fully prepare them for work in social care settings.

- Practice placement organisers in higher education institutions and their counterparts in social care services need to address the shortage of student placements in this area.

- Through organisational recognition of the value of occupational therapy practice placement education in social care services and ensure parity with their professional colleagues e.g. social work.

Directions for research:

- Occupational therapists and managers need to evidence the cost effectiveness of their service provision in adult social care through ongoing evaluations and service reviews.

- To inform and develop future areas of practice, there is a need for in-depth research into service users’ views and opinions of all aspects of occupational therapy adult social care assessments and services.

- To inform service development there is a need to evaluate the effectiveness of integrated occupational therapy services e.g. in health, social care and housing from organisational, professional and service user perspectives.

Section 5: Next steps

The Department of Health commits to:

- continuing to recognise the important contribution that occupational therapists make to meeting the needs of people using health and social care services
- Absorb the findings of this report as part of the development of the Department’s adult social care workforce strategy, which is being taken forward by its adult workforce strategy board.
ensure that the need for an occupational therapy workforce is factored in to workforce planning initiatives (covering both local authorities and the NHS) and the commissioning of education through the Strategic Health Authorities (SHAs).

**Directors of Social Care commit to:**

- work with the College of Occupational Therapists (COT) to develop mechanisms to share best practice in recruitment and retention to address local recruitment and retention issues
- create opportunities for diverse roles that maximise the contribution of occupational therapists
- be prepared to challenge those job opportunities that are advertised specifically for named professionals
- recognise the skills that occupational therapists can bring to strategic and joint planning forums that assist in meeting the local area agreements
- support and encourage practice placements for occupational therapy students
- enable leadership opportunity and resources for continuing professional development (CPD)
- ensure occupational therapy workforce needs are identified to inform future workforce planning
- include occupational therapists in local transformation developments where their contribution benefits service users and carers.

**The College of Occupational Therapists commits to:**

- providing resources to carry out a literature review of research that evidences the cost effectiveness of occupational therapy, future areas of practice and service user evaluation of occupational therapy services within social care
- continue to have a presence on the Social Care Workforce Board to support future development
- seek to develop, in collaboration with the General Social Care Council, career development opportunities for occupational therapists that are more comparable with opportunities available for social work colleagues
- promote best practice and expertise through the COT specialist sections
- seek opportunities to showcase the cost effectiveness of occupational therapy services and the impact on the lives of service users
- Maximise opportunities within SCIE to evidence best occupational therapy practice
- Work in partnership with Higher Education Institutions, social care providers and the Placement Tutors Forum to secure an increased placement provision for students
- Work actively with occupational therapy social care managers to develop an appropriate skill mix for occupational therapy personnel
- work with social care managers to address the occupational therapy contribution to the personalisation agenda
- to develop a position statement for occupational therapists who primarily assess the needs of children and their families within the adult social care workforce
- develop leadership capacity in students, social care occupational therapy practitioners and managers of services to develop innovative and high quality workforce and services through entrepreneurial approaches
- Work actively with the Association of Directors of Adult Social Services to promote occupational therapy and this report
Occupational therapists and managers commit to:

- proactively seek opportunities to create more diverse roles and develop their own careers within social care
- identify and nurture champions and develop talent by positioning occupational therapists in situations that enable them to grow
- networking, learning and sharing good practice
- challenge those job opportunities that are advertised for other named professions
- actively seek to develop the range and scope of practitioners able to offer occupational therapy services in order that professionally qualified occupational therapists manage increasingly complex cases and develop new areas of work
- actively identify ways to market occupational therapy solutions to policy imperatives
- Identify workforce needs and ensure that these are communicated to SHAs for inclusion in commissioning decisions
- take personal responsibility for their own CPD in pursuance of their career development
- Work with service user groups to influence and inform how future services need to develop
Annex 1:

Allied Health Professions:

- Art therapists
- Dieticians
- Drama Therapists
- Music Therapists
- Occupational therapists
- Orthoptists
- Paramedics
- Physiotherapists
- Podiatrists
- Prosthetists and orthotists
- Radiographers
- Speech and language therapists

All the allied health professions are regulated by the Health Professions Council (HPC)

Health Professions Council (2008) Professions Available at: http://www.hpc-uk.org/aboutregistration/professions/ accessed on: 16/9/08
Annex 2:

Project objectives:

1. To establish the current vacancy rate that takes into account current freezing of posts; turnover and recent cuts to services within England

2. To map the current tasks and emerging roles that occupational therapists are employed to deliver within social care in England taking into account the competencies and skills framework

3. To consider how current and future occupational therapy roles in social care will inform and lead to workforce sustainability

4. To determine the current percentage of referrals for occupational therapy against the total referral rate for social service departments

5. To provide practice models and/or evidence of the cost benefit that occupational therapists can bring to a wide variety of services provided within social care

6. To investigate current career structures, career opportunities and limitations for occupational therapist within social care

7. Determine the support needed for new qualifiers moving straight into social care from pre-registration training

8. To evidence the potential for new qualifiers to take on new roles in the wider context in which social care is delivered

9. To identify packages of good recruitment practice that have been successful and that can be endorsed nationally but delivered locally

10. To identify materials that are available for the promotion of occupational therapy as a career in social care

11. To identify leaders and potential champions of occupational therapy who can contribute to its promotion

12. To establish the current provision of student placements in social care settings

13. To investigate the perceived benefits and barriers for occupational therapists employed in social care to taking students on placement

14. To determine the support needed to encourage more practice placements within social care and identify options for shared approaches with social workers
Annex 3:

Project design and methods:

Following receipt of ethical approval from the Association of Directors of Adult Social Services’ research group and the College of Occupational Therapists, the project aims and objectives were addressed through an online survey of local authority occupational therapy adult social care services in England and Higher Education Institutions who arrange student placements in social care settings in England. The survey comprised:

1. Two online questionnaires, sent to all 150 local authorities in England:
   
   I. To managers of occupational therapy adult social care services (n=150 approximately)
   
   II. To all occupational therapists working in adult social care services (n= approximately 1,220 (Information Centre for Health and Social Care 2007)

2. An online questionnaire to Higher Education Institution (HEI) occupational therapy practice placement teams (n = 25)

The questionnaires were designed using the Bristol online survey (BOS) application. Prior to launching the questionnaires, directors of local authority adult social care services and directors of occupational therapy education were contacted in writing with details of the project inviting their department’s participation.

Pilot: To improve reliability and validity, the occupational therapy questionnaires were piloted in local authority social services departments in Wales (n = 22) (OTs n= approximately 200 in 2006 – 2007 (National Assembly for Wales Statistical Directorate 2008)), where the 2004 survey identified similar workforce problems (Social Care and Health Workforce Group 2005). The practice placement questionnaire was piloted with 3 HEIs in Scotland.

The three questionnaires were launched on 5th March 2008 and respondents were initially asked to submit responses electronically by 20th March 2008. E mail reminders were sent to directors of social services, directors of occupational therapy education and occupational therapists in social care services in non-responding local authorities and institutions at weekly intervals. To maximise response rates the questionnaires remained open until 30th April 2008.
Response rates:

<table>
<thead>
<tr>
<th></th>
<th>Expected number of respondents</th>
<th>Number of respondents</th>
<th>Response rate</th>
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<td>OT managers’ questionnaire</td>
<td>150</td>
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<td>647</td>
<td>53%</td>
<td>111</td>
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<td>Practice placement questionnaire</td>
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Breakdown of responses to questionnaires by authority:

<table>
<thead>
<tr>
<th>Number of identified authorities</th>
<th>Authorities responding to both questionnaires</th>
<th>72</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorities responding to OT questionnaire only</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Authorities responding to managers’ questionnaire only</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>121</td>
<td></td>
</tr>
</tbody>
</table>

Data analysis: Questionnaire data were analysed using the BOS data analysis system to generate descriptive statistics and explore relationships among variables.

3. Following a preliminary analysis of the questionnaires, the support needs of practice placement student educators and newly qualified staff (less than two years post-qualification) working in local authorities were addressed through two online focus groups comprising:

I. 17 practice placement student educators
II. 9 newly qualified staff
Sample: Focus group participants were initially identified through the online questionnaires. 87 occupational therapists volunteered to take part in the practice placement student educators group and 42 in the group for newly qualified staff. Potential participants were asked to complete a short online questionnaire to ascertain details of their professional experience and suitability for the group. A letter was then sent to directors of relevant local authority adult social services departments requesting permission for their staff to take part. Once this was given, participants were sent an information sheet outlining the purpose of the focus group and giving ethical assurances. All participants were asked to sign a consent form prior to taking part. The numbers of potential participants reduced at each stage of this process.

To eliminate time spent out of the workplace and accommodate participants’ diverse work arrangements focus groups were conducted asynchronously via a closed e-mail discussion group over a period of five working days. Groups were administrated and facilitated by two members of the research team. Questions were sent to the group on a daily basis and summarised at the end of each day by the facilitator. At the end of the week, participants were sent a digest of the discussion as a whole for comment.

Analysis: Qualitative data generated from focus groups were analysed using NVIVO 7 to establish common patterns and themes. Analyses were cross checked by 3 members of the research team to ensure reliability. Findings are displayed using anonymous illustrations and quotes drawn from data.
Annex 4: Details of research findings:

4.1: Authorities and service provision:

Table 1 shows managers’ responses to the question relating to the delivery of the occupational therapy social care service for adults.

<table>
<thead>
<tr>
<th>Service provider</th>
<th>No: of responses</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority social services</td>
<td>33</td>
<td>52.4%</td>
</tr>
<tr>
<td>Social services and PCT</td>
<td>18</td>
<td>28.6%</td>
</tr>
<tr>
<td>PCT</td>
<td>12</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>63</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 1.

4.2: Occupational therapy referral rates:

Managers of occupational therapy adult social care services were asked for data concerning the number of occupational therapy referrals they had received so that a comparison could be made with the total number of referrals their adult services had received over the same period. For many authorities this information proved difficult to ascertain and only 28 (31.4% of the 82 identifiable authorities responding to the managers’ questionnaire) were able to provide useable figures.

The number of occupational therapy referrals as a percentage of the total number of referrals for adult social care services between April 1st 2007 and September 30th 2007 ranged from 4.31% to 74.71%. The mean of all referrals in relation to the total number of referrals for the service was 34.77%. 53% of responding authorities received between 20 and 50% of their department’s referrals. Figure 1 shows the spread of occupational therapy (OT) referrals to total referral rates for responding authorities.
Figure 1

4.3: The occupational therapy social care workforce:

Occupational therapy respondents by ethnicity

Figure 2
Occupational therapy respondents age range

<table>
<thead>
<tr>
<th>Age range</th>
<th>number</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>11</td>
<td>1.8%</td>
</tr>
<tr>
<td>25-39</td>
<td>236</td>
<td>37.8%</td>
</tr>
<tr>
<td>40-49</td>
<td>218</td>
<td>34.9%</td>
</tr>
<tr>
<td>50-59</td>
<td>142</td>
<td>22.7%</td>
</tr>
<tr>
<td>60+</td>
<td>18</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Table 2

Number of years qualified

4.4: Recruitment and retention:

Respondents to the managers’ questionnaire representing 27 (30%) authorities indicated that they were experiencing difficulty recruiting qualified occupational therapy staff. In 70% of these occupational therapy social care services were provided exclusively by the local authority.
4.4.1: Vacancy rates:

47% of responding authorities indicated they had vacancies for occupational therapists in the period from April 2007 to April 2008. This does not take into account long-standing vacancies that are outside this time frame (figure 4).

Figure 4

Figure 5 shows the spread of vacancies for whole time equivalent (wte) occupational therapists in the local authorities at the time of the survey:

Figure 5
Frozen posts:

18.5% of the 92 responding authorities reported that occupational therapy posts had been frozen between April 2007 and April 2008. This does not take into account posts frozen before 2007 that have not been reinstated.

Reasons given for the freezing of posts included:
- Budgetary considerations
- Organisational issues
- Posts that were not considered to be essential

4.4.2: Changes to posts:

39% of authorities indicated that they had made changes to posts since April 2007. These changes included:

- Changing part time senior occupational therapy posts to full time junior posts; the conversion of senior hours to more occupational therapy assistant (OTA) hours and employing more occupational therapy assistants. Examples were also given of junior roles being converted into more senior posts and assistant posts being upgraded to occupational therapy posts
- The slimming down of management teams
- Money from vacancies being used to target specialist occupational therapy roles e.g. in housing and reablement
- Developing rehabilitation services to meet the modernisation agenda of independence
- Specialist teams created to address particular local issues e.g. waiting list, front of house contact, early intervention and housing adaptations teams.

4.5: Occupational therapy roles:

Table 3 shows that whilst managers' perception of occupational therapy roles generally corresponds with those listed by the therapists in this study, some roles such as commissioning services and carrying out rehabilitation/reablement programmes were more frequently associated with occupational therapy services by the managers than the occupational therapists themselves. This may be a consequence of how the managers interpret these roles than an actual difference in practice, especially since the managers in the Local Authority Occupational Therapy Workforce Survey 2004\(^{55}\) yielded similar figures for occupational therapists' involvement in services such as reablement.

---

\(^{55}\) Social care and Health Workforce Group (2005) *Local Authority Occupational Therapy Workforce Survey 2004* London.\(^{55}\) Social care and Health Workforce Group
Table 3

<table>
<thead>
<tr>
<th>Role</th>
<th>Managers’ perceptions of OT roles</th>
<th>OTs’ perceptions of own role</th>
<th>OTs’ perceptions of the OT support worker role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend Minor Adaptations</td>
<td>99%</td>
<td>100%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Recommend Equipment</td>
<td>99%</td>
<td>98.2%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Issue Equipment</td>
<td>96.7%</td>
<td>97.7%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Assessing for and Recommending DFGs</td>
<td>97.8%</td>
<td>95.7%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Housing Needs Assessments</td>
<td>93.5%</td>
<td>92.6%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Risk Assessments</td>
<td>88%</td>
<td>89.5%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Supervision of Staff</td>
<td>91.3%</td>
<td>80.8%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Checking and Reviewing Service Provision</td>
<td>84.8%</td>
<td>76.3%</td>
<td>55.9%</td>
</tr>
<tr>
<td>Caseload Management</td>
<td>71.7%</td>
<td>74.8%</td>
<td>37.7%</td>
</tr>
<tr>
<td>Other Assessments</td>
<td>69.6%</td>
<td>71.6%</td>
<td>49.8%</td>
</tr>
<tr>
<td>Screen Referrals</td>
<td>80.4%</td>
<td>68.4%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Review Care Packages</td>
<td>39.1%</td>
<td>29.0%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Disability Registrations</td>
<td>23.9%</td>
<td>27.6%</td>
<td>17.3%</td>
</tr>
<tr>
<td>Carry Rehab/reablement</td>
<td>41.3%</td>
<td>24.3%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Commission Services</td>
<td>37%</td>
<td>20.4%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Administer Blue Badges</td>
<td>14.1%</td>
<td>11%</td>
<td>4%</td>
</tr>
<tr>
<td>Return to Work Initiatives</td>
<td>7.6%</td>
<td>4.9%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

4.5.1: Role complexity:

The focus group data indicated that senior staff tend to deal with more complex cases, have more responsibility for the supervision of other staff and take the lead in specialist areas:

“Experienced OTs supervise OTAs and students, as well as reviewing referrals and giving the eligibility criteria and sorting in to OT or OTA cases ready for allocation. In addition to this they attend specialist housing meetings…liaise with care managers and look at new builds and suitability for inclusive design”

Findings from the focus group indicated that changes to career structures and job frameworks in some authorities seemed to blur the roles of newly qualified staff, occupational therapy assistants and experienced occupational therapists.
4.5.2: Innovative/expanded roles:

47% of the respondents to the occupational therapists’ questionnaire said that their role could be expanded to improve the local authority service. Their suggestions included:

- An increase of occupational therapy involvement in rehabilitation/reablement
- Development of return to work initiatives
- More preventative work
- Better links with occupational therapists working in health
- Working with housing and planning authorities to design accommodation suitable for everyone

62.5% of managers provided examples of what they saw as innovative roles for occupational therapists in adult social care, these tended to correspond with the suggestions for role expansion by therapists themselves. However, other examples included:

- Creation of consultancy posts
- Extended practitioner roles in care homes
- Early intervention services with care agency staff.

4.6: Cost benefits:

90% of managers in the responding authorities believed that their service was cost effective. The main cost benefits included:

- Maintaining service users within their own home for as long as possible by early occupational therapy intervention. For example:

  “Enabling individuals to live as independently as possible in the community, rather than residential care”.

  “Supporting clients to live independently without care”

- Cost effectiveness can also be can be assisted by an effective initial assessment team that is able to identify need and direct clients immediately to the appropriate service:

  “Comprehensive screening process and extensive use of unqualified trained staff means that we can be clear about the numbers of referrals which actually require the specialist skills of a qualified OT. This equates to 15% of all referrals received by the authority”.

  “Screening service enables fast provision of minor equipment and adaptation work as prevention to loss of independence”

- The use of occupational therapy assistants and support workers to complement the work of specialist qualified occupational therapists. For example:

  “Good use of OTA time to progress chase and follow up on recommendations”.
“Having an appropriate staff mix so the skills of the qualified OTs are used to their best advantage”

- The use of ‘drop in’ clinics, where service users can come to a local centre:
  
  “… which is a quicker way of assessing clients and more assessments are carried out per day. OT’s do not need to travel to client homes”.

4.7: Contributions to workforce sustainability:

Opportunities for supervision, education and training were identified in the questionnaires and focus groups as contributing to workforce sustainability.

4.7.1: Supervision:

98.2% of respondents to the occupational therapy questionnaire reported that their local authority provides supervision for occupational therapists. In 77.4% of cases supervision is carried by another occupational therapist but other professionals e.g. social workers or general managers also supervise qualified occupational therapy staff.

Findings from the focus group of newly qualified staff indicated that the purpose and use of supervision varies depending on different levels of experience:

“As newly qualified, I think it is more the time frame and the knowledge base that is required, and as time goes on, supervision will look more at specific areas relating to complex clients and what to do in difficult situations where normal/more obvious solutions are not feasible”

Participants in the focus group also indicated that supervision was a helpful process through which they could identify their training needs and discuss opportunities for continual professional development. Peer support groups were also seen as an important mechanism for supporting and encouraging new members of staff.

4.7.2: Education and training:

50.5% of the occupational therapists said that they had undertaken a post-registration course in their current employment. 83.6% of these occupational therapists had received a financial contribution from their employers.

Post registration educational opportunities can be classified as:

- Training in skills relating to the occupational therapy role: e.g. manual handling; building design and adaptations; clinical practitioner courses; wheelchair assessments; telecare; counselling; adult/child protection; mental health awareness

- Management/administrative training and courses e.g. management studies; legislation; information technology

- Post graduate qualifications: masters degrees and modules; diplomas
4.8: Career structures and career limitations:

60% of respondents to the occupational therapy questionnaire indicated that there was a recognised career structure within their department. Examples included:

- Community occupational therapist, senior community occupational therapist, deputy team manager and team manager
- Newly qualified occupational therapist, developing occupational therapy specialist, occupational therapy senior practitioner and team leader
- Fieldworker, practice manager, manager and service manager
- Moving from newly qualified to maturing and experienced practitioner, through to senior practitioner, practice supervisor and/ or team leader. Then to operational manager and principal occupational therapist through to head of service.

There were some indications in the questionnaire responses and the online focus group comments that opportunities to move into specialist/supervisory/managerial roles were limited due to a lack of senior and strategic posts, or in some instances unwelcome:

“Personally, I think that SPOT (senior practitioner occupational therapist) posts here tend to be office based which is something I would not enjoy and feel it would take me away from service users which is the reason I came into OT in the first place.”

The focus group for newly qualified staff gave a clearer insight into the issues associated with career progression:

- The majority of participants felt that there were opportunities to progress in social care services and that the pathway is fairly well defined from the first to second (senior level)
- When posts are removed, progression becomes difficult
- Where occupational therapists stayed in the same posts (mostly at senior level) for long periods of time through choice or lack of opportunity to move into management, this restricted career progression for newly qualified staff.
- Occupational therapy senior practitioner posts require a lot of experience and could be difficult to recruit to.

4.9: The promotion of occupational therapy as a career in social care:

The practice placement educators’ focus group participants reported that their role as a supervisor of occupational therapy students contributed to the promotion of the profession and as a means of attracting future graduates:

“Being seen as a dynamic team that takes students and promotes learning and development always looks good to any outsider. It also gives the students time to look at what areas are of interest to them and gives OT teams and managers a chance to scout for soon to be qualified OTs.”
However, some participants felt more could be done to raise the profile of occupational therapy within social services:

“As OTs I think we are a rather close knit community we all know what we do and what is expected of us….We could raise our profile by taking students from other disciplines. Purely having OT students in an OT environment does not contribute to our professional profile.”

“Often we have social work students or visual impairment rehabilitation officer students who say they wish they were doing OT, we also have OT staff/social work staff or other colleagues whose children/relatives ask re: OT training or go on to training”.

4.10: The current provision of student placements in social care settings:

67.5% of occupational therapy respondents stated that they provide practice placements for occupational therapy students. (This does not take account of the frequency of placement provision). 70.5% of respondents had undertaken a recognised practice placement educator’s course, 53% had completed the course in the last five years. 13.3% were registered with the APPLE scheme.56

An analysis of practice placements and length of time since completing an educator’s course, indicated that more placements are provided by staff who have recently (within the last five years) finished a practice placement educator’s course (85.5 %) compared to 68.4% of occupational therapists who completed the course more than 5 years ago (see table 4).

<table>
<thead>
<tr>
<th>Course Completion</th>
<th>Yes</th>
<th>No</th>
<th>No Answer</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within Last Five Years</td>
<td>196 (85.5%)</td>
<td>29</td>
<td>4</td>
<td>229</td>
</tr>
<tr>
<td>Five Years Ago or Longer</td>
<td>139 (68.4%)</td>
<td>63</td>
<td>1</td>
<td>203</td>
</tr>
<tr>
<td>No Answer</td>
<td>74</td>
<td>105</td>
<td>36</td>
<td>215</td>
</tr>
<tr>
<td>Totals</td>
<td>409</td>
<td>197</td>
<td>41</td>
<td>647</td>
</tr>
</tbody>
</table>

Table 4

Findings from the HEI questionnaire indicated that 92.5% of occupational therapy pre-registration courses in England received offers for placements in social services. 40% of the HEIs also reported that they receive placement offers from care settings other than social services, such as:

• Schools
• Private nursing homes
• Condition management teams
• Charitable organisations e.g. Alzheimer’s’ Association, Age Concern
• Prison Services
• Learning disability teams.

68% of HEIs also said they had access to role emerging placements in social care settings other than adult social care services, which typically included:

• Homelessness projects
• Residential homes
• Schools
• Charitable organisations
• Youth offending services

4.11: Models of student supervision

27.8% of HEIs said they offered long-arm supervision for occupational therapy students in adult social care settings i.e. when supervision is provided by an educator from outside the department where the placement takes place. Other types of placement used for long arm supervision cited by the respondents included:

1. Two role emerging placements: a homelessness project and refugee service
2. Two resettlement projects
3. A drug service.

None of the practice placement focus group participants had experienced long arm supervision and in general they preferred the more traditional models of supervision as illustrated below:

“I have only ever used one to one supervision as I feel this gives the student the best arena to discuss their issues/difficulties and take the time they need to develop their learning”.

Participants also suggested that regular ‘face to face’ contact between an educator and student was an essential element of the supervisory relationship. For example, one participant noted:

“I have not tried long arm supervision but would have some reservation with this, misunderstandings could occur if a student had difficulties expressing themselves clearly or an educator wasn’t clear enough plus the student would be less likely to re- ask a question if they had to phone/email an educator instead of seeing them face to face”.

4.12: The benefits and barriers to taking students on placement:

98.7% of respondents to the occupational therapists questionnaire felt there were benefits to providing placement in social care for occupational therapy students.
Benefits for the occupational therapist included:

- Giving the occupational therapist the opportunity to reflect on their own practice while working with the student
- Development of the occupational therapist’s clinical reasoning when explaining their decisions and working methods
- Keeping abreast of current academic thinking on good practice
- Having an extra resource in a busy working environment, particularly if the student who is nearing completion of their studies
- A contribution towards the occupational therapist’s continuing professional development

For the social care sector, student placements:

- Raised the profile of adult social care within the occupational therapy student population
- Encouraged potential recruitment into social care and to the individual authorities where placements took place

For the HEIs it:

- Created a two way dialogue between the university and practice
- Ensures that practice informs teaching

76% of occupational therapists also indicated that there were issues and challenges to accepting student placements. These included:

- The perceived amount of work it takes to support a student on placement in an environment where the workload is already high
- The lack of time available to support the student efficiently
- The little or no financial reward and appreciation received for supervising a student. The additional workload is not appreciated or recognised by the organisation.
- In a business/target driven culture there is a lack of support from senior managers.
- The worry and responsibility supporting a student brings
- Having to re-teach practical skills where students lack confidence to apply them in the working environment e.g. in moving and handling.
- Constantly changing working practises that make it difficult to strive for consistency and repetition in the student’s learning
- The physical limitations of space and computer access in a hot desking environment.
- Complicated data base system which takes a long time to learn
- The difficulty of matching a full time student with occupational therapists who are working part-time
- The lack of staff available to give the necessary student supervision
- A problem in rural areas if the student cannot drive
- Excessive paper work required by universities e.g. student progress records.
Annex 5: Acknowledgements:

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