directors of adass adult social services West Midlands

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Unlocking the Potential:

Optimising Occupational Therapy as a High-Impact Resource

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Executive Summary

In England there are 14 regulated Allied Health Professionals (AHP), most work within health settings making them the third largest clinical workforce in the NHS. There are around 185,000 AHPs working across the spectrum of health, social care, education (including early years), academia, research, the criminal justice system, and the voluntary and private sectors (NHS England, 2022a).

This report examines how AHP's work in social care in the Midlands and how they can contribute to current and future workforce challenges. Occupational therapists, (as the largest group of allied health professionals in social care), are responsible for 35 – 45 percent of local authority referrals. Despite being only 4% of the regulated social care workforce, they contribute significantly to the health and social care economies (RCOT, 2019).

Occupational therapists working in social care are unique, they specialise in technical and therapeutic interventions that have a significant impact on preventing health inequalities and they actively prevent, reduce, or delay the need for ongoing social care (The Care Act, 2014). For this reason, a `therapy-led approach' in social care is advocated. This would ensure people and their informal carers are enabled to develop knowledge, skills, and confidence to self-manage. With this therapy approach people`s wellbeing, independence, choice, and control are maximised, before long-term care and support is commissioned. This optimises strength-based social care delivery.

Whilst the numbers of occupational therapists in social care are proportionally smaller than the social care worker community, the Royal College of Occupational Therapists (RCOT 2019) argue that they punch above their weight, and funding occupational therapy services delivers a significant return on investment. Evidence from across the Midlands region would support this view; in Nottingham City, Care Act reviews completed by occupational therapy practitioners saved about £1,166 per year, compared to reviews by social work practitioners that saved an average of £659 per year (West Bridgford Wire, 2024). In Telford and Wrekin over £900,000 worth of commissioned care was avoided by an occupational therapy project. There were positive examples of occupational therapy practice, regardless of the size of the service, in every single local authority that contributed to this report.

In summary, there are 1216 individuals making up the social care AHPs workforce in 25 Councils in the Midlands region. There are 594 registered occupational therapists, 323 in the East midlands and 271 in the West Midlands. There are 32 other AHPs, 7 East Midlands and 25 in West Midlands all but one are physiotherapists. There are 395 non-regulated assessors who complete occupational therapy interventions. 220 in the East midlands and 175 in the West Midlands. There are 101 senior practitioners, 57 in the East Midlands and 44 in the West Midlands. There are 94 managers (team managers, service managers and group managers) 49 in the East Midlands and 44 in the West Midlands.

The impact of a social care workforce where Allied Health Professions skills and professional contributions aren't recognised, or their interventions optimised, could lead to a continuation of a more reactive, and less professionally diverse system, where the cost benefits from prevention are not fully realised.

Stakeholders across the Midlands were engaged to develop this mapping and scoping report and AHPs leads in the Midlands region were keen to share workforce development resources to grow a sustainable workforce recognising two enablers: sustainable funding for operational occupational therapy in social care and inclusive workforce development for social care AHPs within the ICS. The key findings of this report are show below.

Key findings

Despite being a linchpin in the social care system, occupational therapists remain under-utilised. Where Councils are not positioning occupational therapy prominently, they are missing out on substantial cost savings from preventative interventions and the best possible outcomes for people and budgets.

Issues impacting social care occupational therapy services across the region include pay disparities, unstable funding, overreliance on temporary positions and inconsistency in the measurement or evaluation of outcomes.

The ambition to integrate the workforce development programmes across ICS's is achievable with sufficient inclusive funding, and strong, sustainable AHP leadership in social care, alongside collaboration with clinical and care professional leaders in the ICS.

1. Introduction

To enable an integrated health and social care workforce, a deep and detailed understanding of the local, regional, and national social care workforce data is crucial, this data intelligence will inform and assist organisational development for our future workforce (RCOT, 2024c). The social care workforce, and its associated support services, is significantly larger than that of the NHS, with jobs provided for an estimated 1.5 million people (Dixon and Jopling, 2023).

The recent Health and Care Act enshrined in law the NHS, Social Care and Public Health responsibility for improving people's health outcomes through collaborative delivery at a local, integrated and system-wide level, to tackle health inequalities (*The Health and Care Act*, 2022). The Act formally merged NHS England and NHS Improvement, giving the Secretary of State, powers of direction over the national NHS bodies and local Integrated Care Systems. The NHS long term workforce plan, a detailed workforce strategy followed (NHS England, 2023).

In March 2023, a government policy *Next Steps to Put People at the Heart of Care* outlined the proposals for adult social care workforce reform (Department of Health and Social Care, 2023a). Criticism by Kings Fund and Care Provider Alliance (CPA) followed for not delivering or delaying on several key elements (Warren and Botterly, 2022); (CPA, 2023). A detailed adult social care workforce strategy has not yet followed. However, in 2024, the LGA commissioned Skills for Care to take on the challenge, and they are now leading on the work to deliver a national adult social care workforce strategy (LGA,2023b).

National stakeholders, representing people who draw down on care and support services, employers, workers, inspectors, and commissioners, such as the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Provider Alliance (CPA), Care and Support Alliance (CSA), Skills for Care, Social Care Institute for Excellence (SCIE) and Think Local Act Personal (TLAP), have collaborated and set a vision for a social care workforce strategy (LGA, 2023b).

By identifying the social care workforce need over the next 15 years and ensuring the sector has enough of the right people with the right skills, employers and commissioners can plan their workforce. In turn, this supports the government's reform agenda, and complements the NHS Workforce Plan, ultimately enabling a more integrated health and social care workforce that can manage the increasing complexity of people's needs (NHS England, 2023); (Care England, 2024); (Skills for Care, 2024).

One of the main reasons for this regional report was the growing awareness of the diversity in social care service delivery involving AHP`s (Beresford *et al.*, 2019b). In the Midlands, there are 25 councils, 11 in the East and 14 in the West, including city and county councils, and municipal borough councils. Each of these organisations deliver place-based health and social care, although commissioning varies across localities to meet the current and future health and social care needs of the local community.

Some councils have separate occupational therapy and social care services, others operate with integrated occupational therapy and social work. Some councils deliver assessment and interventions using an all-age approach, including children. A few councils operate by outsourcing contracts to the independent sector or commissioned the NHS to provide traditional social care occupational therapy work.

This report aimed to scope the social care AHP workforce for both children and adult services in each ICS in the Midlands, describing service delivery models and funding streams used for staffing. We explored the need for, and mapped accurate social care AHP workforce data, social care AHP leadership, integrated AHP workforce recruitment and retention strategies, and AHP collaboration and engagement. From the analysis and evaluation, we identified opportunities to train, retain and reform the social care workforce, for the Directors of Adult Social Care and ICS AHP leaders to consider supporting integrated workforce development.

NHS England have funded, and West Midlands ADASS have hosted this project. Two principal occupational therapists have mapped the social care AHP workforce data for the Midlands region. The data in this report should be interpreted in the context of Office for National Statistics data on population health inequalities (Kings Fund, 2024), and the local operational service differences within councils and the NHS in each ICS. Without more detailed service evaluations, comparison of workforce data between councils is unreliable and invalid, and therefore cautioned against.

2. Doing more with our therapy services

To be effective, therapy service delivery needs to involve the right people at the right time. Occupational therapists, and other AHPs working in social care, are best placed to lead the operational delivery and quality assurance of therapy interventions that enable people to do the activities that matter to them, and which in turn prevent or delay the need for funded social care.

Occupational therapists analyse activities the person wishes to achieve, by considering the person`s abilities (physically, psychologically, cognitively, visually, and sensory), and how they interact with their environment. They work with the person to identify a graded approach to their person-centred goals. Conversely, physiotherapists focus goals to increase physical abilities, including strength and balance training. All social care AHPs focus on what people can do, to give people confidence, choice, control, so care and support is optimised to give better outcomes.

In Coventry and Nottinghamshire, all people new to social care have a therapy-led, strength-based conversation. Figure 1 shows how occupational therapy is integrated with direct care services to provide goal focused enablement (to learn new skills) and reablement (to regain skills) in Nottinghamshire`s Maximising Independence Service. This strength-based approach means long-term care and support is only commissioned if a person really requires it, all preventative interventions have been offered, and after any crisis is stabilised.

Figure 1 Maximising Independence Service Nottinghamshire County Council

Pauline* had been in her garden when she had a stroke and fell to the ground. She was discharged home, and the social worker sourced a short-term package of reablement home care.
She worked with the Maximising Independence Service occupational therapist to identify time limited goals to work on with carers, for personal care, making food, and dressing. After a short-while Pauline advised she no longer wanted the carers to support as she was independent with each task.
Pauline told the occupational therapist she used to meet family and friends in town on a weekly basis, this had stopped since her stroke as the cognitive effects had impacted on her confidence, and as a result she felt restricted to her home. Pauline said what she would like most is to get back into the community and have the confidence to catch the bus and meet with her friends and family again.
The occupational therapist arranged for a Personal Independence Worker to support Pauline to catch the bus using a graded approach and to achieve her goal to participate in community life. Whilst in conversations with Pauline, the occupational therapist identified how distressed Pauline was about neglecting her housework. It became clear she wasn't coping with the household chores, paperwork, and appointments. Another period of reablement was started to work on structured goals around planning, processing, organising, and managing these domestic and life management skills.
In time, Pauline was able to go into town on her own, meet her friends and complete the routine she had established, with reablement, for doing her paperwork and the household chores, so she could maintain her home to her previous standards.
**Anonymised for confidentiality*

2.1 Reablement and discharge to assess.

In 2016, NHS England advocated discharge to assess as best practice, the aim to provide rehabilitation, reablement and short-term care interventions in the community (DHSC, 2024). Figure 2 outlines the four pathways on which people might be discharged from hospital (Department of Health and Social Care, 2024).

Figure 2 The hospital discharge guidance on discharge pathways (Department of Health and Social Care, 2024)

Pathway 0 (50% of people discharged) involves a simple discharge home, with input from health and/or social care.

Pathway 1 (45% of people discharged) involves patients able to return home with new, additional or a restarted package of support from health and/or social care.

Pathway 2 (4% of people discharged) involves recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

Pathway 3 (1% of people discharged) involves patients needing bed-based 24-hour care, including those discharged to a care home for the first time and existing care home residents returning to their care setting.

Reablement has been a consistent service offer delivered by councils for the past 15 years or more, during this timeframe some councils operated with integrated occupational therapy and others had a direct care model (Beresford *et al.*, 2019b). Changes to NHS discharge guidance over the past four years, with the introduction of the 'home first' approach, cemented the need for integrated therapy-led preventative services (NHS England, 2024d). Figure 3 presents Joe`s story of social care, how social care have integrated physiotherapy to their reablement service and how this reduced funded social care in Northamptonshire.

Figure 3 Discharge to assess physiotherapists show reduction of care and support in North Northamptonshire.

Joe* had cancer and had received treatment with palliative radiotherapy, he was admitted to hospital because he was experiencing spasms in the left leg that left him unable to walk. He was discharged from hospital to an assessment bed for rehabilitation.

His goals were "to get home for Christmas, do the stairs, and be able to go out with the family for meals which are already booked."

The physiotherapist from social care worked with him, firstly using a stand aid and assistance of 2 people, then progressing to daily seated strength and balance exercise and standing practice to stand independently. He then began step practise in the gym and progressed to safely doing stairs with supervision. Within a few days he was confident to walk up and down the corridor on crutches with the supervision of the physiotherapy assistant, or independently using his wheeled Zimmer frame.

Outcome measures on admission to the assessment bed were EMS-2/20 and Barthel Index-25/100 and on discharge were EMS-13/20 and Barthel Index-75/100

Joe went home 10 days after admission to the residential assessment setting. He was able to sit to stand from a chair, walk with a wheeled Zimmer, and go up and down the stairs holding onto a stair rail. He had no other social care needs, as his wife agreed she would support with his meals and catheter care. This demonstrated that despite the palliative diagnosis, Jo could still be actively involved in therapy to achieve his personal goals.

**Anonymised for confidentiality*

Most councils have excellent reablement service evaluation outcomes, but few use valid and reliable outcome measures to measure the effect of therapeutic interventions (Davenport and Underhill, 2023). Rutland council have met increased demand through a succession of successful fixed term health funding bids for staffing to secure the growth of the service, 1.5 years of ageing well monies and 1 year of funding through the ICB. This has enabled Rutland's reablement therapy team to incorporate 7-day working to ensure efficient hospital admissions, admission avoidance, as well as offering parity with health colleagues. Without weekend working, delays to reablement therapy commencing would have totalled 23 days for 2022 and 46 days in 2023. The impact for the person, of a two-day delay to start reablement, is a likely decrease in their functional abilities and an increase their care and support needs.

Worcestershire`s approach to reablement is a jointly managed, integrated hospital discharge transfer of care hub. The council and Community NHS Trust's care hub staff negotiate the best pathway, 85% of patients discharged into pathway one in Worcestershire are seen by the council's reablement service, with the remaining 15% seen by the NHS community health teams.

In Nottinghamshire, everyone on hospital discharge pathway 1 is seen by the Council's reablement service, and 85% of people who had reablement were independent at home needing no funded care; Figure 4 shows this intervention is typically lasting less than 20 days. Figure 5 shows the sustainability of Nottinghamshire's reablement services as the percentage of people still at home 91 days after reablement service.

Figure 4 Average length of stay in Nottinghamshire reablement service.

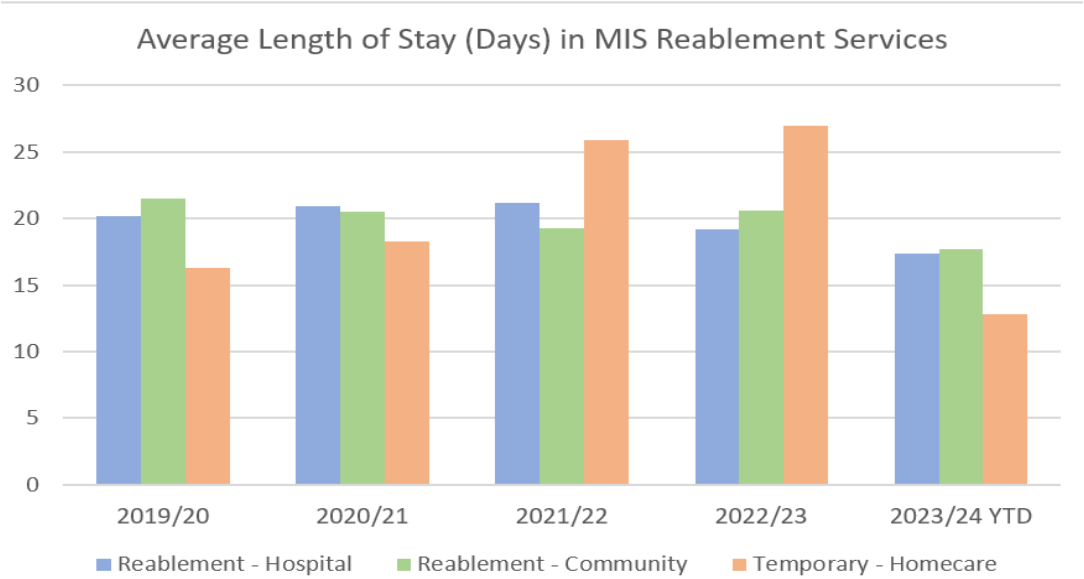


Figure 5 The number of people 65 and over in Nottinghamshire who are still at home 91 days after a hospital discharge to reablement services.

	Year end 19/20	Year end 20/21	Year end 21/22	Year end 22/23	Jan-23	Mar-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	National average 2022/23
Numerator	612	543	430	513	469	513	540	553	544	531	536	568	625	640	650	n/a
Denominator	722	640	504	613	556	613	641	622	600	592	608	655	712	736	761	n/a
Actual	84.8%	84.8%	85.3%	83.7%	84.4%	83.7%	84.2%	88.9%	90.7%	89.7%	88.2%	86.7%	87.8%	87.0%	85.4%	82.30%
Target	83%	83%	83%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	n/a

Proportion of older people who were still at home 91 days after discharge from hospital into reablement services

Similarly, in Wolverhampton, everyone discharged to pathway one, two or three is seen by the council's therapy team or reablement service, and this has expanded to include people with a dementia diagnosis, particularly those in the later stages of the disease who are often not supported by short-term reablement services. This approach is particularly useful when people with dementia are admitted to hospital and suffer an extreme deterioration in their condition, often being discharged to bed care at home or in a residential setting. Figure 6 shows Jack's story and whilst this service is not a quick process, it demonstrates how the team are involved for as long as they need to be.

Coventry Council report they operate an occupational therapy led approach for all people discharged into pathway three, which are health funded residential or nursing beds. In the first year of this new occupational therapy approach 40 people were discharged from long-term residential care to home, compared to 8 people the previous year.

Figure 6 Therapy optimises Jack` s outcomes in Wolverhampton Council.

Jack* is in his seventies with a diagnosis of Lewy Body Dementia, he was admitted to hospital following a fall. Prior to admission Jack lived at home with his wife and he had been able to walk and stand independently. Jack needed to move and walk regularly to control the agitation he experienced due to his dementia.

Whilst in hospital, Jack became unable to stand or walk on the ward, and his distress and agitation increased to such a level he was considered unable to return home. He was discharged from hospital to a residential setting where he was transferred with a hoist and was confined to his bed or chair all day. Jack's agitation levels remained high which made it difficult for his care needs to be met.

The occupational therapist took a graded approach whilst working with Jack in the care home, working with the carers to move Jack with a hoist, and then introducing him to a stand aid. The occupational therapist worked with Jack and his wife to support his discharge home, where therapy could be continued in his familiar environment.

Once home, the occupational therapist issued Jack with a specialist stand aid that enabled him to walk, and social care physiotherapy colleagues then began a walking programme with him. As his movement increased Jack's levels of agitation and distress reduced and his care needs could therefore be met at home easily, by his family and agency carers, (with his care package reduced to a single carer). Jack's therapists are also looking at expanding his daytime activity at a day centre which is now feasible due to his reduced levels of agitation.

**Anonymised for confidentiality*

2.2 Integrating the therapy-led approach.

The therapy-led approach optimises outcomes for people whether they are new to social care, have ongoing social care needs, or for people with complex needs who do not have funded social care. It is especially useful when completing statutory Care Act reviews, for people who receive funded social care, either as direct payment or through the independent home care sector.

Councils are beginning to recognise the value of occupational therapists leading on care reviews. This is more than a focus on moving and handling to achieve single handled care, although this is important, it is about understanding the person, the environment, and the occupation that the person is wanting to do, and then removing environmental barriers, or changing the way the activity is completed, so the care and support is optimised to enable the person to actively participate.

A therapy-led approach ensures that goal-focused occupational therapy interventions are offered during the review period to establish the persons functional capability, or what person can do for themselves. Nottingham City Council have achieved savings using this approach highlighted in the executive summary. A promoting independence pilot in Wolverhampton, compared outcomes for people who had a social work review, joint occupational therapy and social work review, or a stand-alone occupational therapy review. The pilot highlighted greatest ongoing reduction to care, and increase to independence, was achieved by an occupational therapy review, followed by the joint approach of occupational therapist and social worker. Figure 7 shows how Paula was enabled to do more for herself by an occupational therapist in Wolverhampton.

Figure 7 Reviewing care and support in Wolverhampton Council.

Paula* had been in receipt of care for several years because of her complex mental health history. Over the years her care had increased at times of crisis. When Paula was connected to the occupational therapy service, she was in receipt of 46 hours of care each week.

The occupational therapist undertook an extensive assessment of Paula's strengths over several visits and highlighted achievable changes Paula could make to reduce her dependency on care and support.

Paula's social worker used the occupational therapist's assessment to work with Paula in developing a new care and support plan which reduced her care hours over time. Paula's initial response to these changes was not positive, and after complaints were made to the council, Paula took her case to the local government Ombudsman. When her complaint was investigated the Ombudsman found in favour of the council, noting the detailed occupational therapy and social work assessments that had provided the evidence for the changes recommended.

**Anonymised for confidentiality*

2.3 Optimising care through moving and handling.

Occupational therapists have become experts in assessing safe moving and handling, and risk enablement for people to be able to do meaningful activities and occupations. This means supporting people, their informal and paid carers, to do everything from getting up from sitting to standing and getting around the home, to getting in and out of a car and enjoying the community.

As specialist equipment has advanced, and moving and handling techniques improved, occupational therapists have been able to optimise people`s care and support to reduce risk and increase independence. Now, one carer can safely operate a fixed ceiling track hoist and use 4-way glide sheets, whereas 10 years ago, two carers would be required to push, pull, and operate a mobile hoist safely. Not all care can be delivered safely with one carer, each person's needs are carefully assessed along with the carer's capability, the environment and the activity involved, but where care can be delivered safely and sustainably, there are cost efficiencies for the system, and a subsequent increase to care capacity.

Some peoples' abilities change significantly after they get home from hospital due to recuperation, rehabilitation, and the uniqueness of the home environment. There can be an element of caution when care is commissioned because of these factors and there is a need to review moving and handling post discharge to optimise peoples' outcomes. Derbyshire Council were hugely successful delivering single handling care at point of hospital discharge, their occupational therapist in-reached to the wards to ensure the specialist equipment could be trialled.

The occupational therapists at Telford and Wrekin Council created a pilot team who solely concentrated on supporting informal carers with manual handling. They found over £900k of commissioned care was prevented by supporting and enabling informal carers to safely use manual handling equipment so they could continue to deliver the care themselves. Likewise, Figure 8 shows how occupational therapists in Nottinghamshire work with people and their informal carers.

Figures 8 Occupational therapists reduction of care and support in Nottinghamshire.

Mrs Anderson* was discharged home from hospital following a stroke. She was assessed by the acute hospital occupational therapist as needing two carers, four times a day, to assist her to stand using a rotunda turning device. She preferred her husband to assist her to do the few personal care activities she couldn't manage for herself.

The social care occupational therapist worked with Mr Anderson, and considered he was capable and competent to safely operate the rotunda device in their home environment to assist his wife to sit-to-stand without the need for a home carer to do this.

Mrs Anderson wanted to be able to go out with her husband in the car to the shops and on outings. She worked on this goal with the social care occupational therapist, who promoted her choice and control over what might be perceived by some to be a risky situation due to the complexity of environments, and both Mr and Mrs Anderson physical abilities.

This therapy-led approach was successful, Mr and Mrs Anderson gained in confidence through practice and reassurance, this in turn opened new opportunities for them to socialise in their community. Enabling them to be confident to complete moving and handling both in the home, into and out of the car safely, has improved outcomes and reduced the need for home care - a great story of success!

**Anonymised for confidentiality*

2.4 Housing and major adaptations

Research from Public Health England in 2018 found that adaptations resulted in a 23% reduction in hospital admission due to falls and a financial return on investment of £3.17 for every pound spent. It is important to recognise that all social care and Allied Health Professionals working in people's homes are responsible for alerting local councils to unsuitable, unsafe, or dangerous housing.

"The right home environment is essential to health and wellbeing, throughout life. Our homes are the cornerstones of our lives. Housing affects our wellbeing, risk of disease and demands on health and care services. We need warm, safe, and secure homes to help us to lead healthy, independent lives and to recover from illness. We work together, across government, housing, health, and social care sectors to enable this" (Public Health England, 2018 p.1).

When the Ministry of Housing, Communities and Local Government commissioned an internal review in 2018, they found that home adaptations improved quality of life for 90 per cent of recipients, as well as reducing costs to health and care (Mackintosh *et al.*, 2018). Figure 9 tells the story of how major adaptations played a part in enabling Frank to remain at home with his Mum and Dad with no funded social care for many years.

Figure 9 Occupational therapy delays the need for funded social care in Nottinghamshire County Council.

Frank* is 59-year-old and has Cerebral Palsy, learning difficulties and postural issues. He lives with his parents, Bob, and Alice, who are 86 and 80 and who are becoming more aware of their own health needs. They have always provided all care and support for their son. Frank can stand with the use of the rotunda and assistance from Bob, he uses a ceiling track hoist within the bathroom area. Their 3 bed 1930's house has been converted over the years, so it is open plan downstairs, and upstairs, two of the bedrooms made into one to accommodate a vertical lift.

The original vertical lift lasted 16 years. This was replaced 5 years ago, funded by a DFG. The warranty is coming to an end. The family do not have the funds to pay for ongoing maintenance and servicing of the equipment that is essential to enable Frank to continue living at home.

Without the equipment, Frank would not be able to remain at home. Frank wants to live, and he has stated on many occasions that he wants to remain living, in the family home. There is no suitable space for him to live downstairs. All the essential facilities are upstairs. The family do what they can to care for Frank and maintain the home for him to be safe and comfortable.

His Mum and Dad are aware their health is beginning to fail, and so are planning for their son to continue living in the family home long-term, via their niece being given lasting power of attorney. The family are investigating the minimal care and support Frank would require if he was able to remain in the place, he calls home.

**Anonymised for confidentiality*

Figure 10 Frank` s ceiling track hoist over the bath with moulded postural support.

Identifying people's needs in relation to housing and adaptations is a social services responsibility and the Housing Authority needs to consult with social care (*Housing Grants, Construction and Regeneration Act* 1996). Many organisations operate with housing officers or trusted assessors undertaking non-complex interventions such as recommendations for stairlifts or bath-out level access shower adaptations. In contrast people with complex needs, where specialist building works such as ground floor extensions, through floor lifts and complex ramping are needed, will always require social care occupational therapists. Figure 11 shows how integrated working by occupational therapist and physiotherapist can reduce the need for costly major adaptations.

Figure 11 Occupational therapy, equipment and adaptations reduce social care need in Nottingham City Council.

Anita* lives downstairs in her social housing rented home, she walks indoors using furniture to lean on and can't negotiate steps at the entrance to her home or her stairs to access the bathroom and her bedroom upstairs. This is because she has degenerative disc disease, hip pain and foot drop. Anita is also plus size, she is 37 stone, and her body mass index is 80, and she has diabetes type II, sleep apnoea, and bladder incontinence.

When the social care occupational therapist first had a conversation with her, she was unable to leave her home without the assistance of 3 or 4 people. She had funded social care, with 2 carers calling twice a day, to support her with personal care, toileting, meal preparation, and domestic tasks. Her person-centred goals were "*To just feel like Mum again, to have my pride and independence back, to be able to access the community, and make full use of my home*."

Her OT considered re-housing versus a range of home adaptations. Temporary modular ramping was installed to enable her to get out of the property, with priority rehousing as a more cost-effective option than extending the current property (extensive ground works would have been necessary).

An outdoor mobility assessment with community physiotherapy meant Anita`s mobility greatly improved. She was so motivated to achieve her goals she was able to lose 5 stone in weight and was able to get up and down the stairs.

As a result, the social care occupational therapist reviewed the environmental barriers that restricted bathing upstairs, recommending the bath was replaced with a level access shower, and installation of a wash dry toilet. The access to the garden was modified by temporary steps meaning Anita could enjoy the garden with her small children and continue to practice walking outdoors.

Anita was able to sleep upstairs again, in her own bed, use the toilet and shower independently, use her home fully, and care for her family, she was able to access the community and socially participate. She no longer needed funded social care and support.

**Anonymised for confidentiality*

An area to develop is strategic planning for housing, utilising the occupational therapist's expert skills at the planning stage of building design, to future proof accommodation and Figure 12 shows how this can be done. Occupational therapists can expertly interpret complex medical and care needs into appropriate building layouts and use of space (Housing Lin, 2024). Best practice is when social housing providers who are completing new builds, commission an occupational therapist to review the persons needs and architect`s plans, to ensure the design will meet the needs of all future tenants.

Figure 12 Cost efficient uses of DFG for extra care accommodation design by occupational therapists in Derbyshire.

Derbyshire County Council project team were responsible for coordinating architects, design amendments and leading the build of extra care accommodation. This purpose-built scheme, with social landlord rented tenure and leasehold for 55 two bedroomed flats, would have 24/7 onsite staff to support independent living, with care and support available.

Whilst the property and room design were intended to be suitable for a broad range of tenants, typically rooms were adapted with grab rails and level access shower rooms, there were some tenants who would need major adaptations to their rooms.

Joan* was identified as being a suitable future tenant. Joan was a complex lady, she was plus size weighing 35 stone, and small in stature. She rarely engaged in conversation, didn't like to socialise much, couldn't go out from home in her wheelchair because of steps at the door and her main interest seemed to be watching TV.

Joan agreed to move to Potters Place, and the occupational therapist worked with the project manager to ensure the design of the extra care building would be accessible to meet her need for a wider non-standard wheelchair. The occupational therapist arranged for Joan to apply for a disabled facilities grant to fund a wider door with automatic entrance into the flat, wider accessible entrance into the shower room, and to fit a ceiling track hoist over the bed.

This work was cost effective as it was coordinated and completed by the building contractors on site during the main build of the property.

**Anonymised for confidentiality*

2.5 Equipment, minor adaptations, assistive technology, technology enabled care.

Equipment and minor adaptations under £1000 should be freely available under section 2 of the Care Act, as they prevent the need for social care (*The Care Act*, 2014). However, it is assessment, sourcing, and commissioning for the more specialist equipment that occupational therapists are experts at.

The use of a trusted assessor can be a helpful model to manage demand for non-complex preventative equipment and adaptations. However, it must be recognised that even simple equipment provision can create risks or even death for people, for example an off the shelf product like a bed lever can pose an entrapment risk to someone (Medicines and Healthcare products Regulatory Agency, 2023). Regulated occupational therapists are best placed to take accountability for people with complex needs and are ideally suited to be

accountable for the supervision and quality assurance of practice for any non-regulated staff who are assessing and providing equipment provision.

Figure 13 shows how an occupational therapist in Derbyshire County Council led the work to bring Archie home from long-term residential care, and how they determined exactly what specialist equipment would support him at home.

Figure 13 Discharge from long-term residential home reducing care and support by Derbyshire County Council

Archie* had lived in a care home for a long time. He is partially sighted and couldn't stand or weight bear, so he spent most of the time in bed. Archie wanted to live at home with his family, in the community.

After in depth, strength-based conversations with Archie, his informal carers, the social care worker, and the care home staff, the occupational therapist made a home visit to understand any environmental barriers.

The occupational therapy intervention involved working with Archie to see which daily activities he could do himself, and what support he would need to assist him. The occupational therapist considered the needs of his formal and informal carers, balancing the need for his independence with safe moving and handling transfers. This new information was shared with the social care worker, and together they coproduced a care and support plan with Archie and his informal carers.

The occupational therapist used equipment-based solutions to improve Archie`s tolerance for sitting out of bed and to increase his independence with eating and drinking. These included bed with bed rails and bumpers, a high specification pressure mattress, mobile hoist, slings, slide sheets, a specialist postural chair and a specialist tilt-in-space postural shower chair.

The occupational therapist worked with the family and informal carers to ensure they were comfortable with using the moving and handling techniques which enabled safe transfers. This enabled Archie to have a shower with the carers support and assistance. In fact, on one occasion, he was enjoying the feel of the water on his body so much that he asked if the carers could stay longer so he could have a longer wash even though the activity of washing was complete.

On another occasion, he said, how much he enjoyed sitting out in his new chair, particularly by the patio doors as he could feel the warm summer breeze on his face and listen to the birds singing. This little pleasure many of us take for granted, meant so much to him, particularly being partially sighted.

**Anonymised for confidentiality*

2.6 Technology and Artificial Intelligence

Councils use technology to interface with the public at the first point of contact, using technology which can be algorithm driven where specialists have designed the response flow or by using artificial intelligence machine learning.

Such technology at the first point of contact can support people to self-manage their needs with examples such as Ask Sara (Disabled Living Foundation, 2024) for signposting to self-fund non-complex equipment, and a DFG Means Test Calculator (Foundations, 2024) to self-assess potential contributions for major adaptations. Some councils have developed their own tools to enable people to see the range of technology available, Telford and Wrekin Council developed an online smart house for this purpose (Telford and Wrekin, 2024). Other councils like Nottinghamshire are testing AI technology to predict future service demand using risk stratification modelling techniques e.g., falls analytics.

Common products are apps that signpost people to self-manage their conditions, medication reminders, incident management, movement monitoring devices, remote contact with health or care workers, and various inspection or auditing systems. Figure 14 is an example of virtual home care used to support medication self-management, although many councils' reablement services are using day to day technology such as Alexa to achieve a similar outcome.

Figure 14 Independent sector use technology for virtual home care in Nottinghamshire County Council.

Ali* is a 69-year-old gentleman with Parkinson's, Dementia and a pacemaker who is independent in most activities in and out of his home, other than taking his medications. His reablement OT had introduced him to a medication dispenser, but he wasn't tipping the pot correctly and this resulted in him missing medication. The timing and amount of medication were crucial for managing his Parkinson`s symptoms, and therefore he needed support to manage this important need.

The home care agency working with the occupational therapist agreed to trial medication self-management using a simple technology that supports virtual home care, called KOMP

Before the device was installed, he was sceptical as to whether it was needed but he agreed to do a trial after the home carer spent time showing him how virtual home care could help and support him. After the first couple of virtual visits Ali was highly engaged and was talking to the home carer about his favourite TV shows.

Ali and the virtual home carer have now built a great relationship and the medication issue has been resolved and it's being managed well with 3 virtual calls a day from the home care agency. His son and daughter, who were also sceptical to start off with, are now using the KOMP to video call their dad, which has had a positive impact to his mental health and happiness.

**Anonymised for confidentiality*

3. The Midlands AHP Social Care Workforce Analysis

Principal occupational therapists, (or strategic lead occupational therapists) and ICS AHP cabinet and faculty leads across the Midlands informed this analysis of workforce integration readiness. All 25 councils, 11 in the East Midlands and 14 in the West Midlands were either pre-emerging or emerging on the AHP supporting integration matrix scale shown in Appendix 1, Figure 37 (Guyatt, 2022). Nevertheless, the matrix framework enabled conversations about where improvements could be achieved, enabling best practice and innovation to shine through.

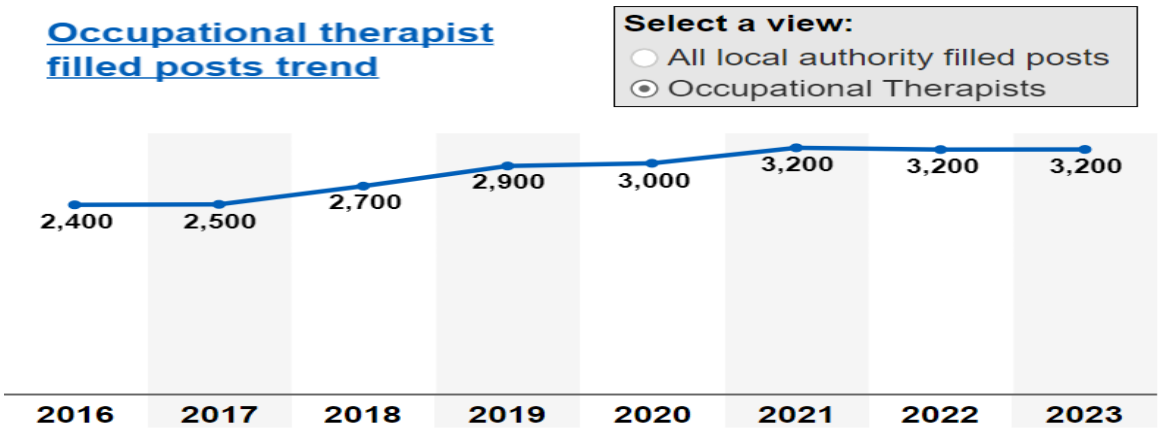
3.1 The workforce data intelligence

The Adult Social Care Workforce Data Set (ASC-WDS) presents useful summary information about the adult social care workforce in England 22-23 (Skills for Care, 2023). It relies on each council submitting their annual workforce data return, but this data does not capture the whole picture for AHPs employed by the local authority.

However, it excluded the non-regulated therapy assessors, other social care AHPs such as physiotherapists, and the senior or advanced practitioners who supervise, and quality assure the competency of others. It counted managers, but not by their registered professional qualification or seniority. Furthermore, some councils provide an all-age occupational therapy approach, including children and so they report higher numbers of workers.

Nevertheless, The state of the adult social care sector and workforce in England report (Skills for Care, 2023), identified there are 3,500 registered occupational therapist posts available in local authorities in England. However, Figure 15 shows a lack of growth in numbers for occupational therapists in the last three years.

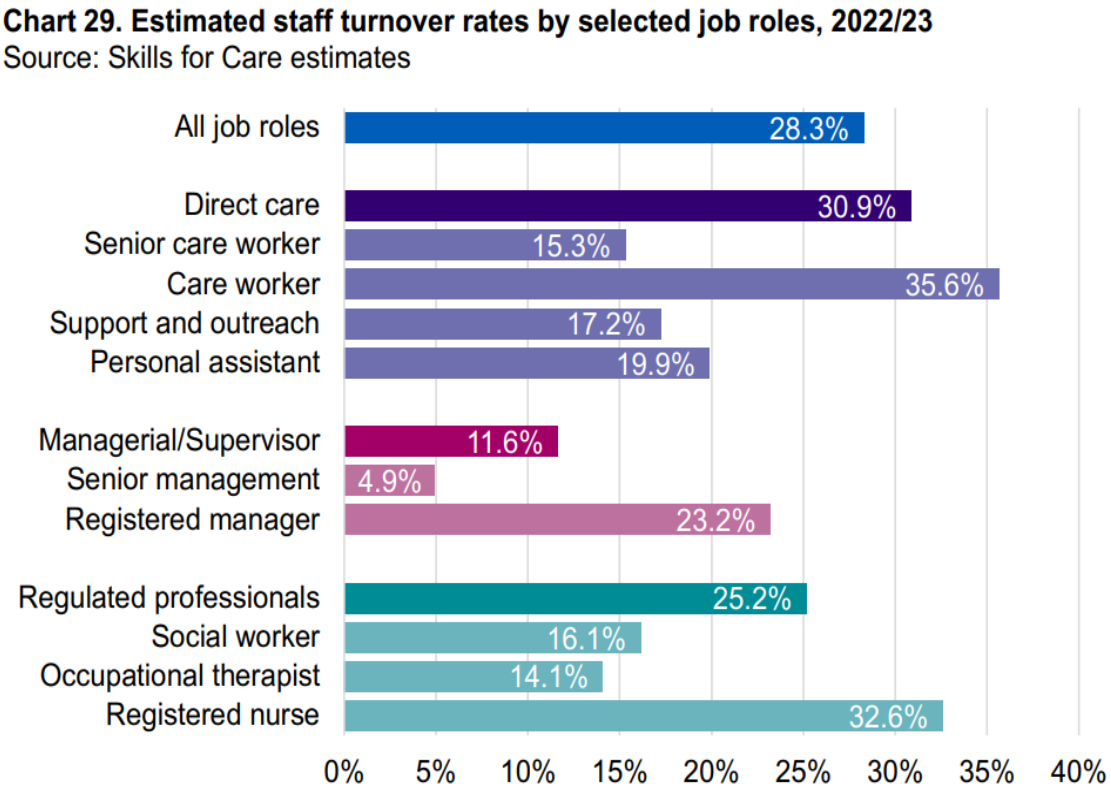
Figure 15 Number of occupational therapists working in social care (Skills for Care, 2023).



The 3,200 filled posts in Figure 15, equate to 2,700 FTE occupational therapists, with 300 occupational therapist posts vacant in England in 22-23 (Skills for Care, 2023). The 9.5% vacancy rate for occupational therapists is average for all roles in social care, although the turnover rate of 13.6% reported by Skills for Care (2023), is below the reported Government national average (Foster, 2024). Demographically, the national average age was 45 years old and 10% were male; there is no ethnicity data available on the Skills for Care workforce report.

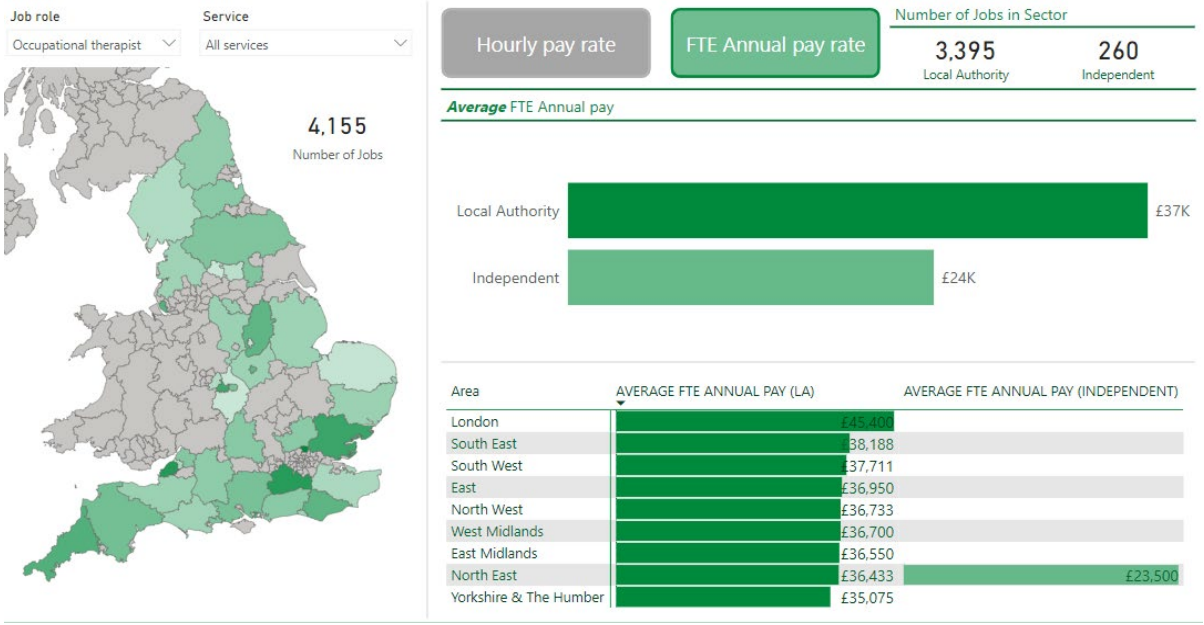
For comparison, Skills for Care (2023) report in England there are 19,300 registered social worker posts in local authorities with 15,400 social workers filling 17,300 posts, that`s 15,600 FTE social workers, 12,700 more than there are occupational therapists. Figure 16 shows the staff turnover for occupational therapy, social workers and nurses working in social care.

Figure 16 Staff turnover in social care in 22-23 (Skills for Care, 2023).



The national data on average pay scale for occupational therapists, is shown in Figure 25 and shows a difference of £10,000 between the regions. This difference in pay does not occur with the other main employer of AHPs, the NHS, because they use a nationally agreed pay scale.

Figure 17 National average annual pay rate for occupational therapist.



a) New in-depth data for the Midlands

To optimise integration, workforce intelligence should be transparently shared across systems. The principal and strategic lead OTs were willing, but not always able, to share workforce data with their ICS AHP faculty colleagues, meaning the proportion of the AHP social care workforce was not comprehended. In part, this was because they had limited understanding of how existing workforce data intelligence was collected and who was responsible for reporting it in councils, and for some councils, parts of the workforce were employed by different organisations.

It was difficult to obtain the workforce data intelligence for this project as the principal occupational therapists either had no mechanism to report on workforce data available to them, or they were stretched with operational duties and competing demands. A workforce business intelligence dashboard would be an enabler for reporting in this situation.

In addition, the use of independent sector contracts to outsource occupational therapy assessments was extensive in some councils, with some councils unable to quantify how many workers were used or the volume of assessments completed. This nuance should be captured in the workforce data intelligence analysis.

Notwithstanding these issues, this project successfully collected detailed workforce data for AHPs from all 11 East Midlands Councils and 14 West Midlands Councils for analysis at all career levels. Children's disability OTs were included in this workforce data to allow comparison because some of the councils operated an all-age occupational therapy service.

In parts of the region, some services were funded by social care but provided by the NHS. Those workers were identified and counted in this data set, but this means NHS data should exclude them and this is a consideration for future workforce data intelligence work.

Occupational therapy degree apprentices were counted separately shown in Figure 23 because of the variance in how councils were funding them. Some were super-numerary to existing substantive staffing structure, others were funded by a delegated decision to convert existing posts, either a substantive occupational therapy post or a non-regulated assessor post. Converting a substantive post has an impact on the workforce capacity to meet operational demands.

In this report all managers, including principal OTs, were grouped together in the tables. It was important to evidence whether social care AHPs had career progression opportunity into senior leadership.

Some councils had a principal occupational therapist, those that did not were Derby, Nottingham, Coventry, Telford and Wrekin, Shropshire, Staffordshire, Herefordshire, Warwickshire, Worcestershire, and Birmingham. The principal occupational therapist role was a senior operational and strategic manager in most councils on a pay band of £55,960 - £68,034 equivalent to NHS Agenda for Change spanning 8a and 8b. However, two East Midlands councils had a principal occupational therapist on significantly lower pay.

b) Occupational Therapists

The occupational therapists were grouped, to include newly qualified, and any subsequent levels of registered occupational therapists who are undertaking operational duties, or who are at this level working in commissioned services such as housing, ICELS, or service improvement teams. Agency workers and occupational therapists who are doing outsourced assessment work were counted if funded by the council.

Figure 18 shows the headcount of Occupational Therapists. There are 594 registered occupational therapists across the region, 323 in the East Midlands and 271 in the West Midlands

Figure 18 Workforce data for all levels of operational occupational therapists (newly qualified and experienced).

East Midlands Councils	Number of OTs	FTE of OTs	FTE Permanent funded	FTE Temporary funded	Vacant posts FTE
Derby City	13	7.85	7.85	0	0.5
Derbyshire County	64	48.14	48.14	0	14.2
Lincolnshire County	40	37.41	37.41	0	0
North Lincolnshire	4	4	4	0	1
Leicester City	21	18.3	18.3	0	1.5
Leicestershire County	30	24.42	23.42	1	5.77
Northampton North County	15	12.95	12.95	0	2
Northampton West County	12	10.4	10.4	0	2
Nottingham City	24	20.1	20.1	0	4.64
Nottinghamshire County	93	73.98	70.98	3	10.51
Rutland County	7	5.5	5.5	0	1
Total East Midlands	***323***	***263.05***	***259.05***	***4***	***43***
West Midlands Councils	**Number of OTs**	**FTE of OTs**	**FTE Permanent funded**	**FTE Temporary funded**	**Vacant posts FTE**
Birmingham City	28	26.4	18.4	8	10
Coventry City Council	24	22.1	21.1	1	0
Dudley Metropolitan Borough	11	10.5	6	4.5	0
Herefordshire Council	7	5.7	1.5	4.2	4
Sandwell Council	14	13.2	6	7.2	2.8
Shropshire Council	10	10	10	0	0
Solihull Metropolitan Borough Council	20	15	12	3	1
Staffordshire County	16	14.74	14.74	0	0
Stoke on Trent City	13	10.7	9.7	1	0
Telford & Wrekin Council	6	5.6	4.6	1	0
Walsall Metropolitan Borough Council	13	12.6	12.6	0	4
Warwickshire Council	34	33.6	27.7	5.9	9.3
City of Wolverhampton	26	22.7	7.2	15.5	1
Worcestershire County	49	47.49	47.49	0	1
Total West Midlands	***271***	***250.33***	***199.03***	***51.3***	***33.1***

c) Other AHPs

Overall, Figure 19 shows there are 32 other AHPs, 7 in the East Midlands and 25 in the West Midlands all but one are Physiotherapists.

Northamptonshire West and Northamptonshire North both employed physiotherapists and unregulated physiotherapy assessors in operational roles, and they were on the same pay scales as occupational therapists. Rutland had physiotherapists on a secondment arrangement, funded by NHS but line managed by social care. Nottinghamshire employed two physiotherapists, one employed in a senior management role, the other employed as a clinical lead in a commissioned equipment service role. Wolverhampton employed a physiotherapist as an expert assessor for blue badge mobility clinics, and a further three physiotherapists to support their home first approach, funded from the Adult Social Care Discharge Fund. Herefordshire and Worcestershire employ physiotherapists in their reablement services.

There were also specific projects considering the use of AHP's in social care, for example in Wolverhampton a dietitian has been employed to explore how good hydration can reduce the need for hospitalisation. The dietitian is working closely with care homes around fluid intake and good nutrition to recognise factors often associated with a person at risk of falls. Care homes are prioritised based on the highest number of reported falls and admissions to A & E. A range of training and advice to individual residents was explored.

Figure 19 Other AHP` s employed in councils.

East Midlands Councils	Number of Other AHP	FTE of other AHP	FTE Permanent funded posts	FTE temporary funded posts	FTE vacant posts
Derby City	0	0	0	0	0
Derbyshire County	0	0	0	0	0
Lincolnshire County	0	0	0	0	0
North Lincolnshire	0	0	0	0	0
Leicester City	0	0	0	0	0
Leicestershire County	0	0	0	0	0
Northampton North County	2	2	2	0	0
Northampton West County	2	2	2	0	0
Nottingham City	0	0	0	0	0
Nottinghamshire County	2	2	2	0	0
Rutland County	1	1	0	1	0
Total East Midlands	**7**	**7**	**6**	**1**	**0**

West Midlands Councils	Number of other AHP and role	FTE of other AHP	FTE Permanent funded posts	FTE Temporary funded	Total vacant posts
Birmingham City	0	0	0	0	0
Coventry City	0	0	0	0	0
Dudley Met Borough	4	4	0	4	0
Herefordshire County	6	6	0	6	0
Sandwell Council	0	0	0	0	0
Shropshire Council	0	0	0	0	0
Solihull Met Borough Council	0	0	0	0	0
Staffordshire County	0	0	0	0	0
Stoke-on-Trent City	0	0	0	0	0
Telford & Wrekin Council	0	0	0	0	0
Walsall Met Borough Council	0	0	0	0	0
Warwickshire County	0	0	0	0	0
City of Wolverhampton	4	2.6	0	2.6	0
Worcestershire County	11	10.6	10.6	0	0
Total West Midlands	***25***	***23.20***	***10.6***	***12.6***	***0***

d) The therapy assessors (non-regulated)

The number of non-regulated therapy assessors are shown in Figure 20, there are 395 nonregulated assessors who complete occupational therapy interventions, 220 in the East Midlands and 175 in the West Midlands. They had diverse roles descriptors meaning it was hard to count this part of the workforce unless they were working in a service or team that was specifically therapy focused. Generally, they were described as officers or assistant practitioners, and all had a role in assessing for care and support and providing interventions associated with occupational therapy or in some cases physiotherapy.

Successful innovation, where new vocational roles, training and job descriptions had been established for non-regulated assessors to risk assess moving and handling, was identified in Northamptonshire West.

Figure 20 The non-regulated assessors who complete occupational therapy interventions.

East Midlands Councils	Number of non-regulated OT assessors /officers	FTE of non-regulated OTs	FTE permanent posts	FTE temporary posts	Vacant posts FTE
Derby City	0	0	0	0	0
Derbyshire County	14	12	12	0	2.2
Lincolnshire County	35	33.34	33.34	0	0
North Lincolnshire	0	0	0	0	3
Leicester City	16	11.8	11.8	0	1.6
Leicestershire County	19*inc housing	18.81	18.81	0	1
Northampton North County	5	5	5	0	0
Northampton West County	6	5.41	5.41	0	0
Nottingham City	21	20.5	20.5	0	2.5
Nottinghamshire County	100	84.86	84.86	0	9.71
Rutland County	4	3.6	3.6	0	0
Total East Midlands	***220***	***195.32***	***195.32***	***0***	***20***
West Midlands Councils	**Number of non-regulated OT assessors /officers**	**FTE of non-regulated OTs**	**FTE permanent posts**	**FTE temporary posts**	**Vacant posts FTE**
Birmingham City	15	14.1	14.1	0	0
Coventry City	18	17.9	17.9	0	3
Dudley Met Borough	15	14.5	14.5	0	0
Herefordshire County	15	12.91	10.91	2	1
Sandwell Council	11	11	11	0	4
Shropshire Council	6	6	6	0	0
Solihull Met Borough Council	7	7	7	0	0
Staffordshire County	18	17.05	17.05	0	0
Stoke-on-Trent City	13	9.9	9.9	0	0
Telford & Wrekin Council	7.5	7.5	7.5	0	0
Walsall Met Borough Council	8	7.7	7.7	0	0
Warwickshire County	20	18.01	18.01	0	1.41
City of Wolverhampton	12	12	7	5	0
Worcestershire County	9	7.24	7.24	0	0
Total West Midlands	***174.5***	***162.81***	***155.81***	***7***	***9.41***

e) Senior practitioners, advanced practitioners, practice leads or practice consultants.

All the adults and children's workers who had a practice supervisory role were counted in this category and are shown in Figure 21. There are 101 senior practitioners, 57 in the East Midlands and 44 in the West Midlands. This group were also described as practice leads and practice consultants, all this group had a role that involved quality assurance of practice, supervision, or workforce development.

Figure 21 Senior or Advanced Practitioners

East Midlands Councils	Number of OT /AHP senior practitioners	FTE of OT /AHP senior practitioners	FTE permanent posts	FTE temporary funded posts	Vacant posts FTE
Derby City	3	2.3	2.3	0	0.5
Derbyshire County	7	6	6	0	0
Lincolnshire County	3	2.56	2.56	0	0
North Lincolnshire	0	0	0	0	0
Leicester City	0	0	0	0	0
Leicestershire County	6	5.54	5.54	0	0
Northampton North County	4	4	4	0	1
Northampton West County	4	3.91	3.91	0	0
Nottingham City	6	6	6	0	0.5
Nottinghamshire County	24	22.23	18.23	4	1.31
Rutland County	0	0	0	0	0
Total East Midlands	***57***	***52.54***	***48.54***	***4***	***3.31***
West Midlands Councils	**Number of OT /AHP senior practitioners**	**FTE of OT /AHP senior practitioners**	**FTE of permanent posts**	**FTE of temporary posts**	**Vacant posts FTE**
Birmingham City	14	14	14	0	2
Coventry City	0	0	0	0	0
Dudley Met Borough	2	2	2	0	0
Herefordshire Council	4	3.05	2.65	0.4	1
Sandwell Council	6	6	6	0	0
Shropshire Council	3	2.5	2.5	0	0
Solihull Met Borough Council	0	0	0	0	0
Staffordshire County	0	0	0	0	0
Stoke-on-Trent City	7	5.7	4.7	1	0
Telford & Wrekin Council	2	2	2	0	0
Walsall Met Borough Council	2	2	2	0	2
Warwickshire County	0	0	0	0	0
City of Wolverhampton	0	0	0	0	0
Worcestershire County	4	3.24	3.24	0	0
Total West Midlands	***44***	***40.49***	***39.09***	***1.4***	***5***

f) Managers with AHP registration

This category covered principal occupational therapists of all grades. Figure 22 shows the grouped data for AHP team managers, service managers, group managers, senior leadership team. There are 94 managers (team managers, service managers and group managers) 49 in the East Midlands and 45 in the West Midlands.

Figure 22 All AHP managers, team, group, and service managers.

East Midlands Councils	Number of OT /AHP Managers	FTE of OT /AHP managers	FTE permanent funded	FTE temporary funded	Vacant posts FTE
Derby City	1	0.8	0.8	0	1.2
Derbyshire County	5	5	5	0	1
Lincolnshire County	9	9	9	0	1
North Lincolnshire	1	1	1	0	1
Leicester City	5	3.8	3.8	0	0
Leicestershire County	5	5	5	0	0
Northampton North County	1	1	1	0	1
Northampton West County	1	1	1	0	0
Nottingham City	2	2	2	0	0
Nottinghamshire County	16	15.31	15.31	0	0
Rutland County	3	2.2	2.2	0	0
Total East Midlands	***49***	***46.11***	***46.11***	***0***	***5.2***
West Midlands Councils	**Number of OT/AHP managers**	**FTE of OT/AHP managers**	**FTE permanent funded**	**FTE temporary funded**	**Vacant posts FTE**
Birmingham City	7	7	7	0	0
Coventry City	4	4	4	0	0
Dudley Met Borough	4	4	4	0	0
Herefordshire Council	3	2	2	0	1
Sandwell Council	0	0	0	0	0
Shropshire Council	0	0	0	0	0
Solihull Met Borough Council	3	3	3	0	0
Staffordshire County	0	0	0	0	0
Stoke-on-Trent City	0	0	0	0	0
Telford & Wrekin Council	1	0.8	0.8	0	0.2
Walsall Met Borough Council	1	1	1	0	0
Warwickshire County	13	11.85	11.85	0	0
Wolverhampton City	4	3.8	3.0	0.8	0.6
Worcestershire County	6	6	6	0	0
Total West Midlands	***45***	***43.45***	***42.65***	***0.8***	***1.8***

g) Student placement capacity and degree apprentices

Each council varied in its capacity to support occupational therapy student placements. Figure 23 shows the numbers of student placements for the academic year 22-23, alongside the number of degree apprentices supported in each council.

The practice educator role was part of the operational occupational therapist duties in all councils. There are stark differences between outliers, with Derby, north Lincoln, Leicester, and Shropshire not taking students last year. Whereas, Birmingham and Nottingham had a similar ratio of students to their numbers of regulated occupational therapists.

Figure 23 Regional student placement 22-23 and number of AHP degree apprentices.

East Midlands Councils	Number of OT students 22-23	Number of AHP degree apprentices	Funding for apprentices
Derby City	0	0	
Derbyshire County	6	2	Substantive (non-regulated post)
Lincolnshire County	14	6	Substantive (OT posts)
North Lincolnshire	0	0	
Leicester City	0	0	
Leicestershire County	1	0	
Northampton North County	5	1	Substantive
Northampton West County	4	1	Substantive
Nottingham City	0	5	Substantive (OT posts)
Nottinghamshire County	30	7	6 super numeri and 1 substantive (non-regulated post)
Rutland County	5	0	
Total East Midlands	**65**	**22**	
West Midlands Councils			
Birmingham City	12	0	
Coventry City	2	0	
Dudley Met Borough	4	2	Substantive OT posts
Herefordshire Council	1	4	Substantive OTA posts
Sandwell Council	0	0	
Shropshire Council	0	0	
Solihull Met Borough Council	2	0	
Staffordshire County	10	2	Substantive OTA posts
Stoke-on-Trent City	2	0	
Telford & Wrekin Council	2	1	Substantive OTA posts
Walsall Met Borough Council	1	2	Substantive OTA posts
Warwickshire County	0	2	Super numeri
Wolverhampton City	4	2	Super numeri
Worcestershire County	11	7	Substantive OTA posts
Total West Midlands	***51***	***22***	

h) Role descriptors, responsibilities and pay scales.

It was difficult to benchmark role descriptors, responsibilities, with pay bands for this project. Generally, there is not pay parity with the NHS for all levels of the social care workforce in the Midlands. Anecdotal evidence also indicated that there was disparity between occupational therapists and social work colleagues in some organisations.

There were five councils, who used NHS agenda for change pay scales for their social care AHPs, with Northamptonshire North and West reporting that this encouraged workers to transfer between health and social care at the same grade.

A deeper dive into the regional data found that social care entry level occupational therapy pay compared more favourably than the NHS national Agenda for Change pay scale. However, after two years this changed, as they would be paid at a higher rate throughout the rest of their career progression if they were on the NHS scale. Figure 24 shows how entry level occupational therapists could be on one of three different pay scales, depending on their employer in the same ICS*.

Figure 24 Pay bands for entry level occupational therapist in Nottingham and Nottinghamshire ICS

Pay bands for entry level occupational therapist in ICS (accurate for 23-24*).

- Local Authority City LGS NJC F Grade (Level 1) £30,296 to £33,024
- Local Authority County Hay Band A £32,076 to £36,648 (annual increments)
- NHS AfC £28,407 to £34,581 (progression bar after year 2).

The diversity in pay between Midlands councils is shown in Figure 25, and there are variations at every grade. The highest paying councils reported less issues with recruitment of staff, and the lowest paying raised concerns around recruitment at the specific grades where pay was lower than other councils.

In some councils, the principal occupational therapist was on the same pay scale as the principal social worker, but in at least two West Midlands councils the pay difference between the principal` s pay scale was over £20,000. In most councils, the principal occupational therapist was on the service manager or above pay scale, except for two in the East Midlands.

Figure 25 Midland councils pay scales by Job family.

East Midlands Councils	scale	Therapy (unregulated) assessor	Entry OT	Experienced OT	Senior/ Advanced Practitioner	Team manager	Service manager
Derby City	NJC Hay	n/a	n/a	£38,223 to £42,403	£42,421 to £46,464	n/a	n/a
Derbyshire County		£27,507 - £29,418	£30,054 - £36,239	£37,339 to £40,638	£41,765 to £45,149	£46,363 - £50,006	n/a
Lincolnshire County	NJC HAY	£30,296 to £33,024	£33,024 to £36,648	£36,648 to £40,221	£40,221 to £44,428	£44,428 to £49,498	£56,769 to £62,278
North Lincolnshire							
Leicester City	LG WEF	£27,852 to £30,151	£27,852 to £30,151	£38,296 to £41,496	£42,503 to £45,495	?	?
Leicestershire County		G8 & G9	£27,858 to £30,078	£31,134 to £34,734. £35,484 to £38,157	£39,282 to £43,128	£44,478 to £48,939	£50,454 to £55,614
Northampton North County	NHS AfC	TI £26,125 - £28,430 MH Assessor £30,115 - £33,798	£29,193 - £35, 001	£35,764 - £49,132	£43,421 - £49,132	N/A	£55,960 - £68,034
Northampton West County	NHS AfC	£25,147 to £27,596 £26,516 to £28,013 £31,869 to £34,663	£28,407 to £34,581	£35,392 to £37,350	£43,742 to £50,056	N/A	£55,960 - £68,034
Nottingham City		£30,296 to £36,648	£30,296 to £33,024	£33,945 to £41,418	£43,421 to £46,464 (+market sup)	£48,474 to £51,515	£53,630 to £56,840
Nottinghamshire County	NJC HAY	£27803 to £31,364	£32,076 to £36,648	£36,648 to £41,418	£41,418 to £46,464	£44,428 to £49,498	£49,498 to £54,679
Rutland County		£24,496 to £26,845	N/A	£35,411 to £42,503 + Market Supplement	N/A	£43,516 to £45,495	N/A
West Midlands Councils							
Birmingham City		£32,076 to £39,186	£32,076	32,076 to £39,186	£40,221 to £48,474	£49,490 to £61,269	62,986-81,154
Coventry City		£23,893 to £27,334	£31,364 to £37,336	£36,648 to £43,421	N/A	£42,402 to £49,498	£53,311 to £57,058
Dudley Met Borough		£26,421 to £28,770	£33,024 to £35,745	£40,221 to £43,421	N/A	£44,428 to £47,420 (assistant team manager)	£57,584 to £61,325
Herefordshire County		£25,979 to £29,777	£32,020 to £36, 298 plus market forces supplement	£36,298 to £40,478 plus market forces supplement of £4,000	N/A	£41,496 to £45,495 plus market forces supplement of £2,000	£46,549 to £50,885
Sandwell Council							
Shropshire Council		£26,421 to £28,179	N/A	£37,336 to £41,418	£42,403 to £46,464	£47,420 to £51,515	£52,579 to £56,571

Solihull Met Borough Council							
Staffordshire County	AFC	£25.147 to £27,596	£28,407 to £34,581	£35,392 to £42,619	N/A	N/A	N/A
Stoke-on-Trent City							
Telford & Wrekin Council							
Walsall Met Borough Council		£31,364 TO £35,744	£34,834 TO £39,186	£38,223 to £43,421	£42,403 to £47,420	£50,512 to £56,239	£54,962 to £60,094
Warwickshire County							
Wolverhampton City	NHS AfC Single Status	None £27,803 to £31,364	£28,407 to £34,581	£35,392 - £42,618 £41,418 to £46,464	N/A	£43,742 to £50,056 49,498 to 53,630	 56,858 to 60,063
Worcestershire County	AFC	£25.147 to £27,596	£28,407 to £34,581	£35,392 to £42,619	£43,742 to £50,056		£50,952 to £57,349

3.2 AHP social care leadership architecture

Generally, there were three main factors that impacted on AHP leadership architecture, the organisational structures for the operational delivery of social care occupational therapy, the need for leadership of AHPs within councils, and the need or benefits of strategic system facing AHP leadership.

a) Operational service design and delivery for social care occupational therapy.

There was considerable diversity in the size of workforce and operational service design and delivery. All but three councils in the Midlands region had a distinct occupational therapy service. From the largest to the smallest council, evidence of health and social care working collaboratively to support with hospital discharge pathways 0, 1 and 2 was found. There were councils who recharged ICBs for assessment and support to pathway 3, completed by social care occupational therapy services.

Whilst each local council's substantive organisational staffing structure was designed to accommodate the population it serves, service models varied and were split by speciality or age, making comparison of leadership requirement difficult. On top of this, there were incidents of temporary funding streams for staffing, mainly used to fund service developments, but also to increase the existing workforce through fixed term contracts, outsourced assessments, and agency staff. In addition, due to the complexity of funding arrangements, we found differing employment models across the region with AHP's employed directly by councils, the NHS, housing organisations and the independent sector.

Regardless of the operational model, the evidence of innovative working was apparent throughout the region with one such innovation demonstrated by Rutland Council shown in Figure 26.

Figure 26 Falls prevention service evaluation in care homes Rutland Council

Rutland occupational therapists found there were 10 times more hip fractures among older people living in care homes compared with older people living in other environments. They agreed to work with care homes to gather hip fracture data to ascertain the rates across Rutland in all settings to evaluate their current therapy offer and identify any gaps. They identified the key people and roles who could make change happen. This involved collaboration at operational and managerial levels, improvement to the accuracy and incidence of reporting through guidance, and joint working and empowerment of staff through raised confidence to help prevent falls. This was achieved with three elements:

1. A falls prevention role undertaken by a social care occupational therapist.
2. A falls prevention forum to network and share good practice for care homes.
3. An assigned falls champion in each care home to liaise directly with dedicated falls prevention therapist.

The service outcomes show a 53% reduction in falls related safeguarding enquiries between 2021 and 2023, and a 47% reduction in falls with injury for the same period.

Jan - April	Safeguarding for falls
2021	19
2022	21
2023	9

Period	No of reported Hip Fractures in Care/Residential Homes
July – December 2021	17
January – December 2022	8
January – December 2023	8

b) Waiting times.

Demand has led to an expansion of the way services are delivered to include virtual, telephone, self, and clinic assessments. Coventry council introduced a booking system which enables waiting times to be expertly managed for people with non-complex needs allowing a maximum wait of 8 weeks. Individuals with high levels of complex needs are seen on the same day (when needed) and Coventry's core therapy duty workers action referrals within four hours, as a result Coventry's waiting times were an exemplar across the region.

Birmingham Council have by far the highest number of referrals into their service, but their waiting times for non-urgent case are less than 20 weeks. Figure 27 explains how the occupational therapists use clinics in the community to engage people in Birmingham in preventative interventions.

Figure 27 Delaying people's need for social care by Birmingham City Council.

Birmingham is managing demand with the introduction of 14 community clinics across the city, in venues where people are encouraged to engage with other activities, in addition to attending an OT assessment (community centres, local halls, places of worship etc). Clinics are run in the north and south of the city daily and are a drop-in service. This means people do not have to wait for an assessment for equipment and minor adaptations to increase their independence.

Clinics have a prevention focus, ensuring people get the help they need earlier. Falls are evidenced to lead to a deterioration of people`s overall health and function, which in turn impacts on their wellbeing. If a person is given good falls prevention advice and is provided with grab rails to assist them around their home, they are enabled to access their community safely, and can socially participate. This means they are more likely to keep active, breaking the falls cycle of deterioration caused by lack of confidence and environmental barriers.

c) The leadership for AHPs within social care

The strategic AHP leadership within social care appeared lacking across the region, with few AHP's at sub-board or senior leadership team level. RCOT defined the strategic nature of the principal occupational therapist role (RCOT, 2021d). This analysis found most principals or equivalent occupational therapy leads in the Midlands, were unable to fulfil the RCOT guidelines as they were employed at a service manager level, with roles and responsibilities that focused inwardly to line-manage staff and lead operational service demand. They reported operational duties placed huge demand on them and left little or no time for them to engage in strategic system facing work.

In Nottinghamshire, 16 AHPs are team managers or above but considering the size of the workforce with a large extended leadership team of around 20 group managers, the 4 who are registered AHPs by background is disproportionately low. In the West Midlands, Birmingham, Solihull, Warwickshire, and Herefordshire, all had a head of service post held by an AHP.

Some of the ICS AHP councils in the Midlands were concerned about the lack of engagement from their social care AHP leaders. Furthermore, where social care AHPs were unconnected or only loosely connected, difficulties presented when working collaboratively as a region for the principal OT and strategic lead network.

In some organisations, the principal social worker was taking responsibility for the quality assurance of all professional practice in social care, and it is difficult to understand how they might adequately achieve accountability of practice standards for different regulated professionals.

The matrix analysis conversations concluded there is a need for both operational management, and strategic system-facing leadership for social care AHPs, to ensure the value and impact of preventative interventions, are raised at appropriate levels for sub-board, steering and operational delivery.

d) ICS strategic social care AHP leadership

Some ICSs already have a chief AHP for their system, one in the East Midlands and two in the West Midlands, and this is an emerging leadership role. A strategic lead OT within each provider organisation (Chief AHP or Principal OT) can focus on clinical and professional leadership, quality of the person`s experience and professional standards, governance and assurance of risk, operational service delivery, transformation of services, and workforce planning and development. As system leaders, they represent their organisation internally and externally at board or sub board level; Figure 28 shows how the matrix analyses identified great innovation and system leadership across the Midlands.

The social care principal occupational therapists and NHS AHP workforce leads gave their views on what works to attract, train, and retain AHPs in health and social care. There was agreement that funding and sustainable resource for these innovation initiatives was the main barrier, as opposed to the enablers which are ideas, innovation, capability, and willingness to deliver projects.

Figure 28 Integrated workforce innovation.

- ✓ Nottinghamshire ICS AHP faculty have designed an online work experience using pre-recorded sessions with each AHP profession leading a descriptive account of their work in each provider organisation. This gives an ideal opportunity for early career AHPs to engage in CPD to design and deliver a presentation to enhance their leadership capability.
- ✓ Black Country ICS are undertaking research aimed at Building AHP capacity throughout the Black Country including within social care.
- ✓ Solihull council have developed AHP placements in social care for physiotherapy & speech and language therapy student placements.
- ✓ Nottinghamshire County Council have leadership student placements in Public Health for pre-reg MSc occupational therapy students to learn about commissioning and service improvement.
- ✓ Dudley Metropolitan Borough Council offer multiple placements within their commissioning team with students taking ownership of specific projects.
- ✓ Several councils have a shared ICS wide AHP preceptorship programme. Meaning newly qualified social care OTs can learn from online CPD modules delivered by experienced OTs from specialist areas of practice in their ICS, programmes include NHS, primary care, social care, independent and voluntary sectors.

Figure 28 continued

- ✓ Leicestershire, Leicester, Rutland, Nottinghamshire, and Herefordshire all have ICS OT Rotations across multiple provider settings including social care for early career OTs. This enables transferable knowledge and skills and networks to develop that support integration.
- ✓ Most Councils used the apprenticeship levy for career development of internal staff to become regulated occupational therapists. Northamptonshire North and West were also using the levy for non-regulated therapy assessors' workers to step up to physiotherapy degree.
- ✓ Dudley Council have converted regulated OT posts to apprenticeship posts to combat recruitment issues and Telford Council convert their nonregulated posts to apprenticeships for similar reasons.
- ✓ Wolverhampton Council use the apprenticeship levy to offer new degree apprenticeship posts which have been hugely popular when advertised and keep the internal nonregulated workforce intact.
- ✓ Nottinghamshire County Council offer a Return to Practice placement offer tailored to individual OTs career aspirations https://www.youtube.com/watch?v=HbeFcVzB5W8
- ✓ Walsall Council offer a 6-month paid induction programme intending to attract registered HCPC OTs from NHS to the experienced social care OT role.
- ✓ Northampton West have developed a moving and handling role and job description for non-regulated therapy workers to allow career progression along a vocational skills pathway.
- ✓ Walsall Council have also introduced Learning Disability and Mental Health Rotations.

3.3 Attracting and retaining the social care AHP workforce.

There were some exciting innovative workforce development ideas shown in Figure 28 that are likely to have an impact on attracting workers to social care. Overwhelmingly, it was reported that flexible working attracted workers to transfer to social care from the NHS, but some workers also wanted to develop their generalist skills.

There was one example of international recruitment for social care AHPs, and this was by an NHS provider who was part of an ICS rotation that included social care shown in Figure 29.

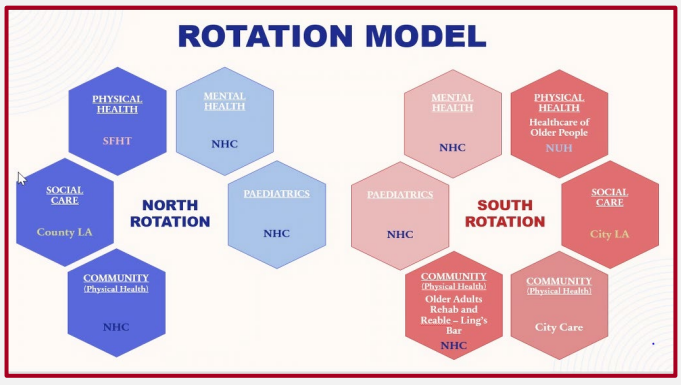
Figure 29 Nottingham and Nottinghamshire ICS early career occupational therapy rotation.

The Nottingham and Nottinghamshire ICS AHP faculty asked students and newly qualified occupational therapists what would attract them to work in health and social care in Nottinghamshire. They asked for rotational posts that spanned the whole system, not just the hospital setting, so they could develop a wide range of specialist experience. This led to strategic collaborative work by senior occupational therapists and HR leads to develop this model.

The Nottingham and Nottinghamshire ICS wide occupational therapy rotation posts are each hosted by an employer within the system, the rotational OT moves every 6 months to a new setting using a secondment agreement model, keeping their employer pay, terms and conditions.

There is a secondment contract for each employer, a memorandum of understanding, and practice guidance for managers to support the rotation. This opportunity for system working was welcomed by the occupational therapy community, we recruited from outside of our system, from Manchester, London and internationally bringing diversity to our profession.

The diagram shows the broad range of placement settings, covering physical, and mental health specialities for adult and children's services in acute, community health and social care settings with the capacity for new employers to join the rotation scheme.



To attract and then retain workers, the council's career pathway development is paramount, and the annual LGA survey for occupational therapists in social care gives benchmarking data for workforce development locally, regionally, and nationally (LGA, 2023). There were some councils who had not developed a career pathway for occupational therapy. North Lincoln and Leicester in the East Midlands recognised they need to address this.

In Leicester City Council, the principal OT was keen to improve the career pathway for social care occupational therapists as it was not fully optimised. Unlike for social work, there was no, supported year in practice (preceptorship), job description for early career occupational therapist, or progression process from early career to experienced role, and beyond. They had not had students for a long

time, therefore the process to access the NHS England placement fee, or return to practice placement payment scheme was not utilised strategically.

a) Student placements

Practice education was valued as a career development opportunity to gain supervisory experience and as a source of future recruitment. Figure 23 showed the placement capacity generated within the regions social care workforce in 22-23. Of the 25 councils in the region, 18 had offered student placements to higher education institutes in the year 22-23. A commitment to practice placements can enhance recruitment and facilitate career development for practice educators. Figure 30 outlines how practice education can be incentivised in organisations to expand placement capacity.

Figure 30 Student placement capacity expansion.

- ✓ Use of NHS England placement fee to incentivise Practice Educators.
- ✓ Practice Educator accreditation as a career progression competency.
- ✓ Creative solutions for students who lack transport.
- ✓ Virtual online Placements.
- ✓ Group supervision placement models (2:1 or groups).
- ✓ Long arm supervision models.
- ✓ Placements in emerging social care settings e.g., Public Health, day care opportunities and care homes.
- ✓ Leadership placements.

Some councils were significantly more proactive in this space, with others rarely or never engaging in practice education. Derbyshire, Nottingham, Shropshire, and Leicester councils considered individual worker operational capacity and demand, and /or lack of vacancies the main reasons to not invest in student placements in their councils. Whereas Nottinghamshire were trailblazing with the number of placements offered, and the use of the long-arm placement model to support senior occupational therapy managers to easily have students and create innovative occupational therapy leadership placements in public health. Similarly, Dudley Council have expanded their student placement offer to include exciting project opportunities with the commissioning team.

Within the Midlands the higher education institutes that provide occupational therapy courses are Derby, Sheffield, Lincoln, Coventry, Northampton, Worcester, and Wolverhampton. In the East Midlands a new course is being accredited for Nottingham Trent University, and in the West Midlands a new course is set to commence at Birmingham Newman University. Birmingham Council have already offered four placements to the new training programme, ensuring new students are enabled to experience social care work from the outset of their training.

The matrix conversations led to the discovery of exciting placement opportunities for other AHPs to experience social care and this was pleasing, this could be a rich

and rewarding area for integrated workforce development. An example was Solihull Council who host physiotherapy, paramedic, and speech, and language therapy placements.

b) Degree apprentices

The recruitment of apprentices for regulated degree professions in both social care and the Midlands ICS was small scale. For occupational therapy degree apprenticeships, there are fewer courses available: Sheffield, Coventry, Northamptonshire, Worcester, and Wolverhampton. This means the apprentice course is more available and accessible in respect of travel costs to the West Midlands councils.

Figure 23 shows there were 44 AHP degree apprentices in social care in the Midlands. The matrix framework conversations informed that most councils were focused on internal staff career development, mainly funded through a delegated decisions process to convert roles, with no funded backfill or supervisory support. In effect, this was considered to not be growing the workforce effectively and was placing more pressure on existing staff to supervise practice and manage operational capacity and demand, without additional resource.

There could be more strategic modelling using the staffing budgets plus apprentice levy to recruit external applicants to grow the workforce for the future. When Wolverhampton created new occupational therapy degree apprentice posts, the response from external applicants was extensive with over 100 applications per role.

c) Supported first year in practice.

Attracting and supporting newly qualified AHPs requires specific additional resource to ensure they are competent and safe to practice. Some will not have had a social care placement and will need more support than others. Some councils advocated that social care AHPs use the existing social work assessed and supported year in practice programme but produce their own profession specific portfolio of evidence for local accreditation. Herefordshire council developed an innovative social care competency framework for newly qualified OTs which was nationally adopted, and locally adapted (Skills for Care, 2019).

Other councils had aligned with the ICS preceptorship programmes, evidencing rich benefits of cross system networking and shared learning at the early career level. A great example of shared therapy online CPD sessions was in Nottingham and Nottinghamshire ICS, with each specialist OT setting in the system contributing, including primary care, social care, and the independent and voluntary sector. This also meant experienced staff had the opportunity to enhance their own skills by delivering the presentations.

d) Work experience and return to practice.

Attracting school and college students to social care, and role modelling a career as an allied health professional, is a gift our occupational therapy workforce can give. Some workers are proactive in this space, delivering career talks in the community and at higher education institutes, and this is to be encouraged as it enhances their leadership capability, confidence, knowledge, and skills. This type of workforce development initiative can be shared across the ICS and is an example of how all 14 allied health professionals can participate by recording an online presentation with an in-depth description of their role in their provider organisations across their system, including social care.

A different type of work experience requirement is return to practice placements, these are hosted within organisations and placements are funded by NHS England (RCOT, 2024b). They are an effective way of recruiting experienced professionals who have taken an extended carer break. The returner completes their tailored learning objectives that comprise of 60 hours of mixed theory and placement experience.

Only a few Councils had pathways for returners, Nottinghamshire Council reporting that all five of their return to practice OTs in the last 3 years, had secured permanent jobs after their placement, suggesting this is an area other councils may wish to development.

3.4 Collaborative AHP learning and development, and workforce initiatives.

The matrix analysis conversations gave limited evidence of collaboration in terms of shared learning and development across systems in the Midlands region.

There have been national improvements to enable access to the NHS Leadership Academy and e learning portals (NHS England, 2024f) giving more equity for online CPD for social care and independent sector AHPs. However, when we spoke to principal OTs and OT strategic leads, they weren't all aware of these leadership resources.

In Derbyshire, as part of the joined-up care initiative, there was a community health led training session for social care occupational therapists to learn competency in strength and balance training, with a similar social care led session about major adaptations and disabled facilities grant process. In Wolverhampton and Staffordshire there were social care led training sessions for acute trust staff in manual handling, legislation, and specialist equipment.

In Worcestershire, the therapy model adopted by the Community Health Trust led to extremely close ways of working and a joined-up approach to workforce development and recruitment, with most staff undertaking social care work employed by the NHS.

An exciting Integrated therapy transformation project shown in Figure 31 by Leicester, Leicester, and Rutland (LLR) was led by ICS colleagues and the Leicester principal occupational therapist. It involved a shared learning training package, with practice guidance, and a memorandum of understanding between community health and social care AHPs.

Figure 31 The LLR integrated personalised care framework.

The LLR Framework for Integrated Personalised Care

It has been developed to support the undertaking of therapy tasks on behalf of a partner agency in a way that is safe, appropriate, and equitable. It is designed to facilitate constructive and effective dialogue, supported by national legislation and guidance, between partners across the LLR Integrated Care System and is comprised of management and operational process using ten principals. The therapy guidance uses the universal, targeted and specialist skills and competency framework.

1. Care and Support is person-centred.
2. The person is an expert by experience.
3. A strength-based approach is used.
4. Home first ethos- supporting people in the place they call home where-ever possible.
5. Quality assurance of practice through effective clinical governance
6. MDT decision making
7. Efficient use of resources.
8. Trusted assessment - if you are there, and competent, then do the task.
9. Make Every Contact Count
10. Reviews are timely and effective.

Specialist tasks which cannot be delegated they require a specific skill set.

ASC Tasks	Health Tasks
Ceiling track hoists Complex Single-Handed Care Interventions Complex moving and handling including carers/reviews. DFG applications Major adaptations – bathrooms, through floor lifts, access Complex adaptations Safeguarding enquiries for falls & section 42s Blue Badge assessments	Complex seating/positioning Skin integrity/pressure sores Respiratory patients – COPD/Pacing/function/energy conservation Contractures & hand function Neuro input (CINSS) Palliative/deteriorating patient – Home first step-up patients to prevent Admission. Use of the NEWS 2 scoring system. Mental Health clients – Mental Health OTs Complex Trauma – RTAs with multiple injuries

Targeted Tasks which can be delegated but training, monitoring and clinical oversight will be needed.

Housing MOT referrals
Basic adaptations – Straight forward Stair lift/LAS/Ramps
Ceiling track hoists – Straight
Assessments for shower chairs/ benches/ stretchers etc.
NRS equipment – portable ramps and other access solutions
Certain minor adaptations
NRS – mobility equipment provision
Assess simple mobility issues.
Assess simple strengthening exercises.
Assess simple ROM exercises to aid function.
Rehabilitation of ADL's
Home first element – 2-hour response/triage
Some Single-Handed Care Interventions

Universal generic tasks which any Therapist or Therapy Assistant (or other roles which are deemed to be equivalent) can complete.

Holistic assessment
Minor adaptation recommendations
NRS equipment provision
Transfer Practice
Kitchen activities – assess and practice.
Mobility Practice
AT recommendations
Bathing assessments can be delegated to Health colleagues if there are already working with the Person i.e., providing a Therapy package.

Most councils have limited funds for workforce development and can only offer mandatory social care training. Nevertheless, there was an excellent example of collaboration between academic researchers in HEI and NIHR students who worked in Nottinghamshire adult social care and public health, with shared CPD sessions, and access to filler places on university online, and face to face taught modules for topics on prevention, stroke, and falls.

4. Discussion

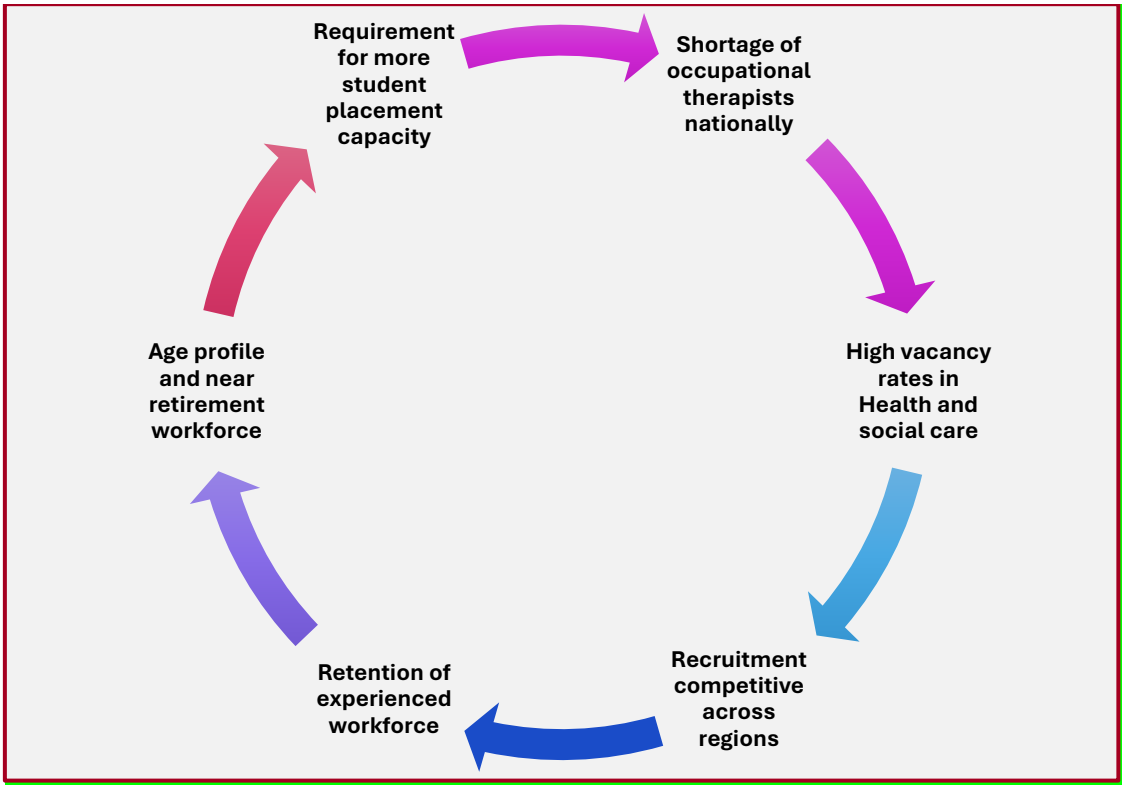
This report has clearly outlined the largest group of AHPs in social care is occupational therapy, and that occupational therapy interventions can have preventative impact, value and be cost effective for organisations giving positive outcomes for people.

The discussion aims to synthesise the data analysis findings with the evidence-base for integrated working, and present the opportunities to train, retain, and reform the social care AHP workforce, to align with the future adult social care workforce strategy (Skills for Care, 2024a), (LGA, 2023b).

4.1 Train

To attract both regulated and unregulated AHPs into social care, investment into workforce development and strategic leadership are required. The principal and strategic lead occupational therapists should work collaboratively with health, voluntary, community and social enterprise partners to build their future workforce. This may be through apprenticeships, sharing best practice regarding practice-based learning opportunities and expansion, and through early recruitment (Skills for Care, 2024a). Figure 32 illustrates cyclical impact of high vacancy rates on the occupational therapy workforce.

Figure 32 Shortage of occupational therapist cycle.



Given the impact and value of their preventative work, it is common sense to pay attention to securing a healthy supply pipeline for occupational therapists. The matrix analysis identified a need for more supervisory support for entry level preceptorship programmes, OT degree apprentices, and more student placement capacity to enable experiential learning to encourage students to work in social care.

Furthermore, occupational therapists, like social workers, are on the national shortage occupation of skilled workers visa register (UK visa and immigration, 2021) but no councils in this Midlands analysis were optimising the opportunities for ethical international recruitment for AHPs.

a) Work experience and return to practice.

Shared resource is needed to fund workforce development programmes that coordinate AHPs across their ICS to allow collaboration by working together on a common workforce development vision. The examples of innovative system working, generated in the analysis, must be sustained, and new ideas nurtured. There were three key areas around work experience that would develop an integrated mature approach: an ICS shared approach for school and college work experience; use of a talent bank process to identify where shadow experience could develop transferable skills or tailor work experience for both regulated and non-regulated workers, and access to return to practice AHP placements focusing on welcoming and supporting qualified, but unregistered AHPs into both health and social care settings.

b) Increasing student placement capacity.

There is such opportunity to host placements in social care for a wide range of AHPs, especially those who work in generalist fields. Skills for Care (2024) consider it to be a unique opportunity for learners to reimagine their relationships with people, families, and society and recommend at least one social care placement for occupational therapists and other AHPs, alongside opportunities for placements in public heath that focus on preventing health inequalities.

Research suggests paramedics developing their knowledge and skills around people's wellbeing in relation to their home environment would be valuable (Allana and Pinto, 2021). Figure 28 shows Solihull council already offer physiotherapy, paramedic, and speech and language therapy student placements. The matrix conversations allowed good practice to shine through, with ideas to increase practice educator capacity and quality of placements.

c) Recruitment of apprentices.

NHS England commissioned a report on the opportunities to tackle workforce shortages in social care, and the apprentice model is seen to be a solution in part (WMADASS, 2023). DHSC have released funding bids to support recruitment, coordination and supervision of social workers, and social care nurses in 2024/2025, it was disappointing that social care AHPs were not concomitant in phase one, although it is understood that phase two will rectify this. There are risks for the AHP workforce development in social care, primary care, and independent sector if no funding is available for degree apprentices, the coordination infrastructure, or for AHP supervisory capability. Specifically, if additional workforce funding is targeted at the NHS only, then social care will not have the infrastructure to train and retain apprentice occupational therapists.

To enable the apprentice model to feed the future pipeline of AHPs in health and social care we need to implement at scale. Sustainable funding would enable cost effective, shared (system facing) services, targeted external opportunities for recruitment of AHP degree apprentices provided year-on-year, including on costs for supervisory resource to quality assure practice, and the increased number of practice educators required.

With investment, the apprentice model primarily used now to enable internal career development in most provider organisations, could be extended to recruit external applicants. This would address the pipeline shortage for all AHPs and enable strategic sharing of an integrated health and social care workforce. Shared services for coordination, recruitment, and onboarding would support providers, and recognition of the practice resource required for the day-to-day supervision, increasing placement capacity and associated need for practice educators would give best value for money.

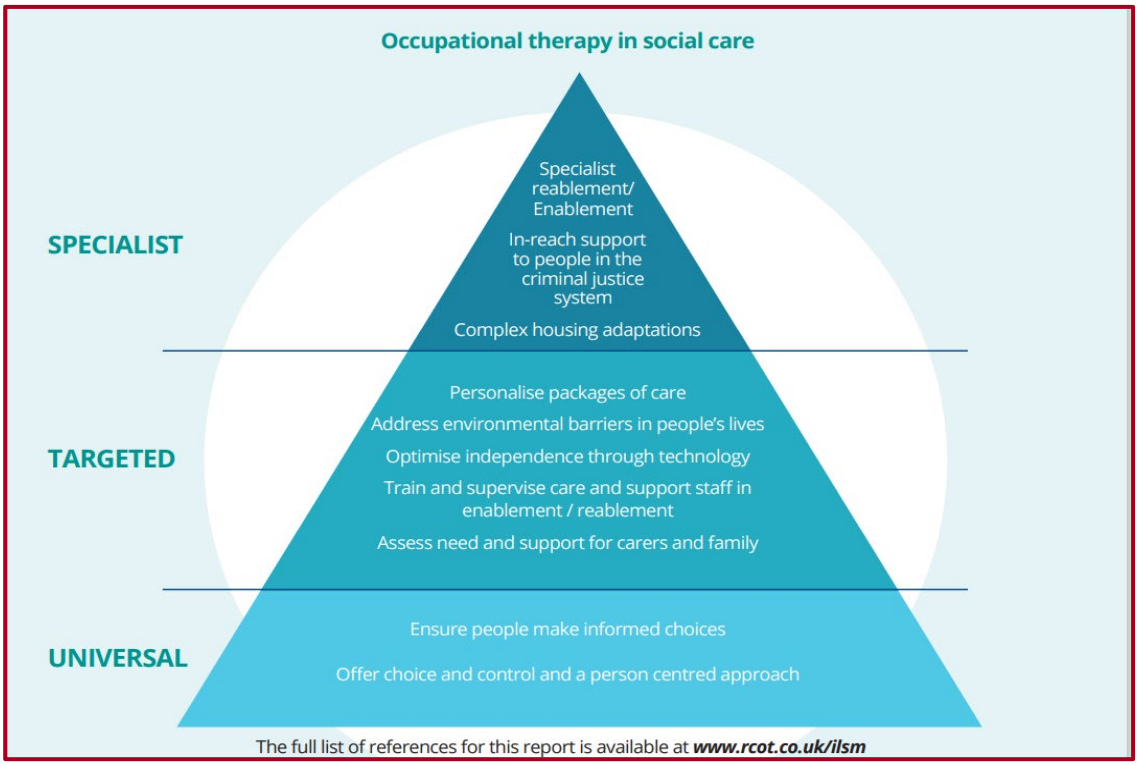
d) Non HCPC regulated occupational therapy assessors.

As a profession, occupational therapists have been an integrated part of the social care workforce for decades, Figure 32 shows how occupational therapy interventions are split into universal, targeted and specialist levels of support to encourage the growth of the non HCPC regulated therapy assessor workforce. NHS England (2024d) outline four principles for community rehabilitation and reablement for the future.

1. Maximising the use of the registered and unregistered therapy workforce based on the expertise and skills required and the point in the pathway where it is required.
2. Supporting delivery by a multi-disciplinary, multi-agency workforce working in integrated ways, pulling in relevant skills, expertise and community assets as required.

3. Ensuring rehabilitation assessments and interventions are therapy-led and overseen by a registered therapist who will offer advice, support and guidance as required, with strategic oversight for quality, including safety.
4. Utilising digital interventions to supplement and support access to rehabilitation and to clinical expertise.

Figure 33 Specialist, targeted and universal social care occupational therapy (RCOT, 2024a)



Developing the non HCPC regulated workforce to be competent to deliver universal or targeted occupational therapy interventions takes time and resource to train and quality assure competency of practice. Figure 19 showed some Councils had invested in this with significant numbers of non-regulated staff providing these interventions.

It is essential that workers who prefer not to take an academic route have the opportunity to progress their vocational skills in matrix or portfolio careers. Support workers can progress to a degree AHP apprenticeship or a leadership and management role using apprentice routes (WMADASS, 2023). It was interesting that a non-regulated moving and handling assessor role had been developed in one council to deliver targeted interventions.

In addition, for the non-regulated assessors or assistant practitioners who want an academic step-up to a degree apprenticeship, local providers of the assistant practitioner (health) apprenticeship have been slow to offer and only offer competency physiotherapy or occupational therapy, focusing more on nursing, and so this is a career development gap requiring more development.

4.2 Retain

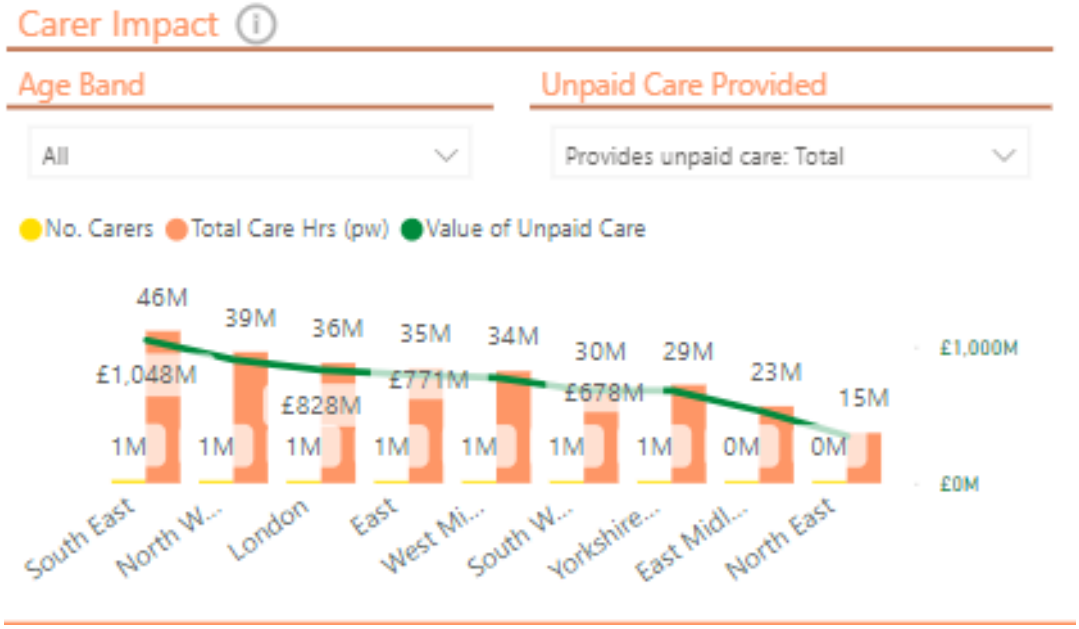
As occupational therapists we want to belong in our profession, our organisation, and our system, so we can deliver better outcomes for people. We want to grow our careers and for our transferable skills to be recognised, so we can move between sectors, specialities, and organisations, without penalty or unnecessary duplication of training to evidence competencies. To do this we need to consider worker wellbeing and career development opportunities in the context of EDI, professional equity, pay terms and conditions, and how we support the informal carers within our workforce.

a) Worker wellbeing

The matrix analysis indicated that flexible working was what kept people working in social care. The data showed headcount of staff is much higher than the number of whole time equivalent suggesting high numbers of workers enjoy part time hours. In Wolverhampton, one OT described how they had never worked harder than in their social care role, but their work/life balance had also never been better. Conversely, Derbyshire County Council reported they were struggling to recruit to their new reablement team because of the need for an operational commitment to weekend working.

Dixon and Jopling (2023) report an estimated 4.7 million people provide unpaid care to friends or families, and some of those people work in health and social care. It is important to value this, to look after them and support them to be informal carers. If they choose to take a career break, support them back into practice when they are ready. This means a focus on return to practice programmes that lead to appointment within Councils or ICS.

Figure 34 Unpaid carer estimates in England (ADASS, 2024).



There are specific employer standards for the following professional groups and applicable to social care sector and the local authority: social workers (Local Government Association, 2020); occupational therapists (Local Government Association, 2023); nursing workforce standards apply to any organisation employing nurses including social care and the independent sector (Royal College of Nursing, 2021); public health (Local Government Association, 2018) which includes guidance for nurses and health visitors who are employed by local authorities to deliver on the healthy children national programme office (Office for Health Improvement and Disparities, 2023)

There is no national professional standard or evidence-base for the amount or weighting of complexity for occupational therapy case work. The LGA employer standard for occupational therapists (standard 3) refers to transparent and safe working levels in each service area that enhance more direct relationship-based practice. Workload should be allocated transparently, effectively, and regularly assessed with each occupational therapist, taking into consideration their experience, their professional judgement of capacity, the work complexity, and any time needed for supervision and CPD (Local Government Association, 2023).

In terms of worker wellbeing, the implications of less staff shouldering an increasing demand of highly complex case work is not sustainable long term. The Royal College of Occupational Therapists (RCOT) conducted a workforce survey in 2022, completed by 2,600 participants working in both health and social care in the UK, and found that 86% reported an increased demand for OT services within the previous 12 months, 79% attributed it to lack of capacity elsewhere in the health and care system and 79% stated that people were presenting with more complex needs due to delayed interventions (RCOT, 2023).

> "Pressures within the role currently are mainly to do with volume of work and recruitment issues rather than issues specific to occupational therapy as a career." (RCOT, 2023 p.7).

The LGA employer standards for occupational therapy set out the shared core expectations of employers which will enable occupational therapists in all employment settings to work effectively and safely; the annual survey in 2022 received 16,000 responses from 140 organisations (Local Government Association, 2023). The key findings from this survey showed that standard 2 (effective workforce planning) was received most favourably and the lowest level of satisfaction was shown for standard 6 (continuing professional development). Other concerns identified were their strategic partnerships across systems and their case recording systems. There was a clear difference in response between permanently employed occupational therapists and those employed by an agency, or who are interims or independently working, in relation to the employer standards and their workplace experiences (Local Government Association, 2023).

The key recommendations from the RCOT survey were that Government must recognise that investment in the NHS and social care is critical to a

healthy population and therefore economic growth; investment in the occupational therapy workforce must be matched to service and demographic need in the NHS and social care; capacity should be built within primary and community health and social care services, to ensure people receive advice and help early on, rather than when in acute need or with increased complexity due to delayed intervention (RCOT, 2023).

> "Being told not to work to gold standard due to capacity issues provides a huge amount of stress." (RCOT, 2023 p.2).

b) Equality, diversity, and inclusion.

The equality, diversity, and inclusion (EDI) of the AHP workforce reflects the protected characteristics enshrined in legislation (*Equality Act*, 2010). Accurate workforce data intelligence is needed to drive EDI improvements that ensure fairness across professional groups. Councils should assure themselves that employment standards are met, and the pay, terms and conditions in social care settings are equitable across systems and regions, benchmarking with other councils delivering social care across England.

The intention to gather workforce equality, diversity, and inclusion data was not achieved, in part due to EDI data for AHPs not being available to the operational managers, or because the AHP workforce was so small that individuals could be identified. This was concerning, increasing the diversity of the social care workforce is paramount and required to support inclusive leadership, in line with the Diverse by Design principles (LGA, 2023a); (RCOT, 2024b).

c) Parity of esteem, pay, terms and conditions.

The regulated professions in our social care workforce stretched between the independent sector, councils, NHS, housing and home improvement agencies across adults and children's services, and in our Midlands, region include social care nurses; social workers; occupational therapists; physiotherapists, and a dietitian. Establishing parity of esteem across multiple professionals in an organisation is critical to worker well-being, so smaller but vital professions such as occupational therapy are attracted and retained.

More leadership at a strategic level for AHPs is required in social care, which Directors of Adult Social Care could recognise and address. Senior leadership teams with social work or business backgrounds, leading occupational therapy services (or AHPs) as part of a portfolio are unlikely to identify or challenge the system-wide, taken-for-granted practices that historically may have limited or concealed AHPs' strategic contributions to health and social care.

The government funding for workforce development is passported from DHSC and social care occupational therapists repeatedly report that they cannot access

funding for CPD, and that they fall through the funding silo gaps (Local Government Association, 2023). The implications of this are post graduate training, available to NHS colleagues, is not inclusive of social care AHPs.

The sustainability of the non-regulated assessor workforce, qualified by experience but without a professional degree that entitles regulation, was concerning because of the range of pay between councils and the impact this had on the internal degree apprentices.

Councils who had lower threshold pay bands, reported they struggled to recruit to that level of worker, so for example, Leicester struggled to recruit to team managers and newly qualified roles, and in Derbyshire they found recruiting non-regulated assessors hard.

The analysis showed a difference in pay bands between occupational therapists and social workers at the same level of practice, doing similar roles, with the use of market supplements or honorariums to top up the pay for certain roles. This disparity in pay was reported to negatively influence workers wellbeing and led to workers moving between neighbouring councils to enable progression to higher pay scales. A common national pay scale for social care could have a beneficial impact on worker wellbeing.

c) Agency or Bank workers

The use of agency staff in social care is widespread amongst councils. Agency workers can either be extremely experienced staff, workers who are less skilled, or those who are starting out in their careers in the independent sector. This can cause unpredictable quality assurance of practice complexities. There were regional exemplars that aimed to improve the quality of practice and reduce the cost of agency staff, some councils had a temporary register of staff they could use for deployment. An excellent memorandum of understanding between councils in the West Midlands for Children's services, to pay agency rates at specific levels attempted to reduce over inflated costs, and this is in progress for implementation with adult care (West Midlands ADASS, 2022).

The use of a temporary register of workers or organisational bank can expedite recruitment timescales for HR checks, this is particularly useful for workers who wish to relocate from other areas and intend to apply for vacancies when they become available. Figure 35 describes how Stoke Council partnered with the NHS to use their temporary bank using NHS pay terms and conditions to recruit staff during the Covid pandemic.

Figure 35 Integrated recruitment by Stoke City Council

Stoke City Council worked with their integrated care system ICB People Hub to recruit people who had not worked in the care sector before. They used a values-based recruitment approach to the NHS temporary staffing bank (reserves), recruiting using NHS pay, terms and conditions at band 2 and 3, with a secondment agreement with social care. The line management, training and supervision were delivered by social care to assure the competency and capability of the new staff.

This model generated new home care staff from the community in a way that maintained stability of the market. It also attracted nursing students, who

The Department of Health and Social Care works in partnership with hospital Trusts to provide a national temporary bank service called NHS Professionals. Highly skilled temporary workers looking for a long-term placement, or who want to work flexibly within the NHS can register. This initiative available to Allied Health Professionals, Healthcare Scientists or Social Workers is saving the NHS over £70 million each year (NHS Professionals, 2024).

4.3 Reform

Baird *et al.* (2024) described the unaligned workforce development in health and social care, identifying larger growth in the acute hospital sector compared to primary and community sectors. An integrated workforce can deliver cost savings, reduce demand on hospitals, provide better experiences and outcomes for people, improve service alignment or integration, develop population health and prevention at scale, including wellbeing, and tackle inequalities (Baird *et al.*, 2024). By positioning the allied health professional workforce, particularly occupational therapists, where they can focus on prevention and early interventions, the need for crisis interventions and dependency on care services is minimised (RCOT, 2024c)

In terms of workforce reform, there were some areas of interest discovered from this project that might improve outcomes for people whilst having a positive impact on over stretched budgets. Whilst small, the occupational therapy workforce has proven themselves to be extremely effective, and investment, targeted at developing a workforce that can deliver therapy preventative interventions could be beneficial to all. The case studies shared shine a light on the value of occupational therapy, and showcase, through real stories, how therapy interventions add value and impact. If timely access to social care therapy optimises people's outcomes, which interventions are most impactful, when, and why, and how are these therapy interventions and outcomes measured?

Baird *et al.* (2024) opinion is that a sustainable health and care system delivering improved care and outcomes, rather than delivering short term cost savings, is needed. Meaning all policies, including investment, workforce, financial architecture, and performance management policies, must be aligned to the integrated workforce vision (Baird *et al.*, 2024).

Across the region, the data and the matrix conversations evidenced a lack of supervisory staff to assure quality of practice and professional standards for occupational therapy workers. Where there was no principal OT, or the lead OT was an operational manager, there were reports that internal workforce development did not include occupational therapy, and integrated system facing workforce development was lacking.

a) Funding

Temporary funding, such as the adult social care discharge fund and market sustainability grant have been used to alleviate staffing pressures, introduce new ways of working, and for recruitment of occupational therapy workers to support the therapy-led pathways one and two for hospital discharges. The findings in Section 3.1 showed a third of the councils are reliant on temporary funding to sustain their therapy services and whilst short-term funding is useful for invest to save innovation, where it is shown to optimise peoples care and support, the continued use of temporary funding is not a sustainable approach, as it creates increased fragility in services.

Baylis *et al.* (2023) reported the piecemeal nature of multiple separate streams of funding to ICBs and/or local authorities intended to reduce discharge delays. In addition to the £500 million Adult Social Care Discharge Fund and the £250 million hospital discharge fund, reducing delayed discharges was also at least one objective of the £1.08 billion adult social care grant for 2023/24 announced in the 2022 Autumn Statement, and an objective of three workforce funds from January 2021 to March 2022 (Baylis *et al.*, 2023). Furthermore, the Better Care Fund has had a focus on reducing delayed discharges since its inception, and the government has now extended discharge funding to be delivered through the Better Care Fund to £600 million in 2023/24 and £1 billion in 2024/25 (Baylis *et al.*, 2023).

b) Role descriptions

In this analysis, much confusion occurred due to the diversity in role descriptions between councils. This had relevance when discussing pay, terms, and conditions across the region. It would be helpful to undertake a consensus exercise to support councils and ICS in the region to have a common coding descriptor for social care roles, Figure 36 gives an example. This also includes the descriptions used for care worker roles in the newly published care workforce pathway for adult care (DHSC, 2024). ICS AHP colleagues also reported confusion, the way

managers input roles on ESR is not standardised, impacting on data reporting and likely to lead to coding errors; this issue was also found in some councils.

Figure 36 Suggested AHP role descriptors.

Home care:
a. New to care
b. Care or support worker
c. Supervisor or leader
d. Practice leader

Unregulated professionals:
Therapy assistant (practitioner or officer)
Therapy assessor (practitioner or officer)

Regulated HCPC Registered professionals
Entry level (Newly qualified) Practitioner
Experienced Practitioner
Senior /Advanced Practitioner
Practice lead or team lead (operational or team level)
Clinical Academic (Research Practitioner)

Managers:
Team Manager (operational line management)
Service Manager (operational & strategic for 2 to 3 teams)

Senior Leadership Team
Principal or Consultant Practitioner (whole service & strategic practice lead)
Group Manager (operational & strategic for multiple teams)
Head of Service (operational & strategic)
Service Director (whole service strategic lead)
Director (whole service strategic lead)

c) Education and training

Sharing resource across the ICS for education and training would be cost effective and beneficial. If the NHS England funded AHP workforce projects and programmes at a national and regional level and were inclusive, to ensure AHPs at local system-level could access the benefits in any provider setting, it could change the health and social care sector.

We found positive examples of this in the Midlands, for example an AHP support workforce implementation lead, who is developing a suite of resources to support ICBs to implement the AHP Support workforce career, competency, and education framework, which included all providers and sectors. In Nottingham and

Nottinghamshire ICS, the ICB were using the apprentice levy to reach out across the system providers for executive level 7 leadership apprenticeships.

There were concerns raised about recognition of advanced practice in social care, and how this might fit with an advanced clinical practice accreditation. Social care advanced practice included occupational therapists who were best interest assessors, advanced mental health practitioners or who had other post graduate qualifications in specialties. In fact, there was no clear practice capability framework beyond entry level for AHPs in social care. There was recognition of the need to support the transferability of training skills between health and social care for AHPs.

Promotion of clinical academic pathways can support research into practice yet for those social care AHPs who wished to develop academic skills or a career as a clinical academic, there was no local funding available in councils. Nationally, NIHR offer competitive programmes for social care clinical academic programmes, and there were instances of take up amongst AHP in social care.

There are also national, regional, and local AHP Clinical Fellow opportunities that AHPs working in social care can apply for, these are secondments hosted by participating provider organisations, but none were hosted in social care. Many councils weren't aware of these national and regional funding schemes, and therefore there is a need to broaden the information sharing through networks. Finding ways to support collaborative learning between NHS and social care is an area for development across the region.

d) Increase the professional diversity of the social care workforce.

There is ample evidence to suggest other AHP`s would benefit from working in a social care setting. Art and music therapists who can direct interventions designed to reduce agitated behaviour in care homes. (NIHR, 2023). Podiatrists working with people in homelessness settings, or nursing and residential homes, as good foot health reduces falls. Speech and language therapists working with people who have had head injuries (Andrews and Botting, 2020). Paramedics working in the community to reduce hospital admissions, for example by visiting vulnerable people at risk of admission and supporting them at home, in extra care or care homes to manage urgent medical complexity, and unscheduled care (Health Education England, 2023), (Eaton *et al.*, 2021), (Eaton, 2023), (Allana and Pinto, 2021).

5. Conclusions

This report investigated the Allied Health Professionals working in social care across the Midlands, who were predominately occupational therapists. They are a vital part of the adult social care workforce delivering valued preventive interventions with significant impact to individuals and the wider health and social care economy. They should be invested in and positioned within the workforce to give maximum impact (RCOT,2024c).

There were three key findings from this report.

1. Despite being a linchpin in the social care system, occupational therapists remain underutilised. Where Councils are not positioning therapy, as a preventative first offer, they are missing out on substantial cost savings from preventative interventions and the best possible outcomes for people and budgets.
2. Issues impacting social care occupational therapy across the region included pay disparities, unstable funding, overreliance on temporary positions, and inconsistency in the measurement or evaluation of outcomes.
3. The ambition to integrate the AHP workforce development programmes across ICS is achievable with sufficient inclusive funding, and strong, sustainable AHP leadership in social care, alongside collaboration with clinical and care professional leaders in the ICS.

To grow our workforce for the future we should recognise why people are attracted to work in social care. Flexible working practices, and the privilege of working with people in the place they call home, with the people they love, doing what matters to them in their communities, is an incredible honour. However, these incidental factors are not enticing enough for all workers who are planning their careers. Employees also want career opportunities, continued professional development, sustainable contracts, and good pay.

This Midlands workforce data analysis showed councils had low numbers of allied health professionals, mainly occupational therapy workers, who were completing highly impactful and vital preventative work.

Obtaining the AHP workforce data for this project was difficult, with no data cleansing or reporting mechanisms in place in most councils. An accurate workforce business intelligence dashboard would be an enabler for workforce development, reporting locally, regionally, and nationally. Nevertheless, the data gathered showed there was a high number of temporary staff in the West Midlands with disparate funding streams used for staffing.

This report found capacity to grow a wider social care operational therapy offer by stabilising the workforce through secure funding routes, attention to simplification of common occupational therapy operational processes, evaluation of outcomes,

quality assurance of capability in practice, and increasing the ratio of regulated workers to supervise the non-regulated workforce.

This report articulates the vision for an integrated health and social care AHP workforce. With strong strategic social care AHP leadership, coordinated and inclusive funding for health and social care AHPs workforce development within systems, and the opening of opportunities for other AHPs to experience working in social care settings, an integrated health and social care workforce is possible.

This context warrants stakeholders having a collective understanding of the national AHP social care workforce issues. Using workforce data to predict gaps and measure impact will enable codesigned strategic solutions for better, more integrated workforce planning for AHPs locally, regionally, and nationally to ensure the pipeline of staff recruited and retained is optimised. Health and social care can be transformed (Baird et al, 2024) and workforce reform can enable an integrated workforce between NHS, primary care, independent sector, and social care.

6. Considerations for future research.

Overall, some areas for consideration generated from the findings of this report could be investigated through further research.

1. How might Directors of Adult Social Care support the ICSs to investigate a shift towards an integrated health and social care workforce development offer for AHPs, with shared access to training to increase collaboration and system leadership, that is inclusive of primary, social care and the independent sector.
2. Considering the two regions in the Midlands footprint, what value and impact would a social care Chief AHP leadership resource bring, does an ICS Chief AHP have more, or less impact, for the social care workforce and the operational delivery of therapy services for people across our regions?
3. Considering the need to mitigate risks of fragile operational therapy services in the Midlands region, how might we improve AHP social care workforce data intelligence and measure or evaluate the difference that therapy interventions make on peoples' outcomes, including who delivers them and when, and the impact therapy-led preventative approaches have on population health equality?

7. Appendices

Appendix 1

The AHP Matrix Framework to support integration.

Figure 37 Framework for AHP supporting integration.

Framework for AHPs Supporting Integration [6]			
1. Integrated AHP workforce data and intelligence	**Emerging** • Principal OTs /AHPs in local authorities (LAs) nominate somebody to work alongside their LA data representative to ensure data is correct for input to the annual Skills for Care data set. • Clear internal understanding of the current workforce and creating plans for the future workforce in local authorities.	**Developing** • Shared workforce planning: Building relationships with Integrated Care System (ICS) AHP Councils/Faculties, bringing social care data to the table, and having collaborative conversations for the benefit of the people we deliver services to.	**Maturing** • Fully integrated data aligned with Electronic Staff Record (ESR)/NHS data and local authority data collection. • Ownership taken by each PSLOT in local authorities to input into Skills for Care data set; directly aligning with the priorities of the Long-Term Workforce Plan.
2. Leadership and AHP architecture for social care	**Emerging** • Building relationships and rapport between regional PSLOT chair and Regional NHS England AHP Leads. • Involvement with AHP Councils and Faculties. • Ensure diversity and inclusion in representation in the PSLOT networks.	**Developing** • Fully functioning and sustainable PSLOT networks in each region. • All 152 local authorities have a named Principal OT. • Ongoing collaboration with professional bodies (e.g. RCOT). • Robust links and relationships between regional networks, and wider AHP networks, AHP Councils and Faculties at system and regional level. • Utilising the key principles of Clinical and Care Professional Leadership (CCPL) as an enabler towards diverse and integrated leadership.	**Maturing** • Sustainable business support for the regional PSLOT networks and task-force. • All Principal OTs identify as an AHP Lead within their local authority. • Clearly defined and direct links into: DHSC, ADASS, LGA and Skills for Care via the regional and national PSLOT network. • PSLOT representation in all health and social care strategic decision-making and pathway development activity e.g. intermediate care and care workforce pathway.
3. Attracting and recruiting the social care AHP workforce	**Emerging** • Sharing and taking on board best practice and showcase examples of Occupational Therapy in local authorities within systems, regions and nationally. • Actively offering social care as an AHP career option. e.g. liberating placement expansion in local authorities.	**Developing** • Recognition and development of AHP roles in local authorities and wider sectors of social care, inclusive of the voluntary and charitable sector. e.g. role-emerging placements. • Local authorities working with Higher Education Institutions (HEIs) to recognise and promote the value of a social care career. • Social care AHPs guest lecturing on local HEI courses.	**Maturing** • Clear and equitable AHP workforce development frameworks for both social care and health that are fully aligned. e.g. integrated AHP support workforce strategy, rotational posts across health and social care. • One workforce offer at place-based level: Coordinated and fully aligned approach to pre-registration attraction and post-registration career development opportunities, with fluidity across health and social care as equal partners.
4. Collaborative learning, development and AHP workforce initiatives	**Emerging** • A mutual appreciation of all AHP roles across social care (local authorities) and health (NHS). • A clear understanding of workforce learning and development requirements within both social care and health.	**Developing** • Joint and equitable access and availability of all relevant learning and development opportunities across health and social care at place-based, system and regional level. • Collaborative practice education and practice-based learning models across local authorities and NHS organisations. e.g. hybrid student placements. • Shared continuing professional development (CPD) and training opportunities across all levels of staff. The beginnings of more collaborative thinking across preceptorship, enhanced (ECP), and advanced (ACP) level practice.	**Maturing** • Integrated services and aligned workforce initiatives at place and ICS level. • Integrated approaches to workforce and succession planning: e.g. cross-organisational rotations, flexibility of workforce through skills passporting. • Enhanced practice programme working across health and social care settings. • Developing advanced practice training opportunities; building a flexible skills-set across health and social care. • Mutually agreed consultant AHPs driving fundamental shifts in service delivery across health and social care.

8. References

Allana, A. and Pinto, A. D. (2021) 'Paramedics Have Untapped Potential to Address Social Determinants of Health in Canada', *Healthc Policy,* 16(3), pp. 67-75.

Andrews, L. and Botting, N. (2020) 'The speech, language and communication needs of rough sleepers in London', *International Journal of Language & Communication Disorders,* (55), pp. 917-935.

Baird, B., Fenny, D., Jefferies, D. and Brookes, A. (2024). Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/making-care-closer-home-reality (Accessed: 26.02.24).

Baylis, A., Bottery S., Tiratelli, L., Benniche, S. and Wenzel, L. (2023) *Hospital discharge funds: experiences in winter 2022-23*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/reports/hospital-discharge-funds (Accessed: 26.02.24).

Beresford, B., Mayhew, E., Duarte, A., Faria, R., Weatherly, H., Mann, R., Parker, G., Aspinal, F. and Kanaan, M. (2019b) 'Outcomes of reablement and their measurement: Findings from an evaluation of English reablement services', *Health & Social Care in the Community,* 27(6), pp. 1438-1450.

The Care Act (2014)(c 23) National Archives (online)

Care England (2024) *Skills for Care to develop workforce strategy for adult social care*. Available at: https://www.careengland.org.uk/skills-for-care-to-develop-workforce-strategy-for-adult-social-care-as-new-report-shows-a-year-of-green-shoots-and-ongoing-challenges/#:~:text=The%20strategy%20will%20identify%20the,people%20with%20the%20right%20skills.

CPA (2023) *Care Provider Alliance*. Available at: https://careprovideralliance.org.uk/ (Accessed: 08.09.23).

Davenport, S. and Underhill, A. (2023) 'The use of outcome measures and factors affecting their use in social care occupational therapy', *Irish Journal of Occupational Therapy*. DOI: DOI 10.1108/IJOT-02-2023-0006.

Department of Health and Social Care, (DHSC) (2021) *People at the Heart of Care: adult social care reform white paper.* London: UK: Gov.uk.

Department of Health and Social Care, (DHSC) (2023a) *Next steps to put People at the Heart of Care.* London: UK: Gov.uk.

Department of Health and Social Care (2024) *Hospital discharge and community support guidance*. Available at: https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance (Accessed: 05.02.24).

DHSC (2024) *Care workforce pathway for adult social care: overview*. Available at: https://www.gov.uk/government/publications/care-workforce-pathway-for-adult-social-care/care-workforce-pathway-for-adult-social-care-overview (Accessed: 26.02.24).

Dibsdall, L. (2021) 'Selecting from their toolbox of interventions – A realist study of the role of occupational therapists in reablement services', *British Journal of Occupational Therapy,* 85(7), pp. 513-522.

Disabled Living Foundation (2024) *Ask Sara*. Available at: https://asksara.livingmadeeasy.org.uk/selector (Accessed: 05.02.24).

Dixon, A. and Jopling, K. (2023) *Time to act: A roadmap for reforming care and support in England*, UK: The Association of Directors of Adult Social Services. Available at: https://www.adass.org.uk/media/9687/adass-time-to-act-april-2023.pdf (Accessed: 17.01.23).

Eaton, G. (2023) 'Addressing the challenges facing the paramedic profession in the United Kingdom', *British Medical Bulletin,* 148(1), pp. 70-78.

Eaton, G., Wong, G., Tierney, S., Roberts, N., Williams, V. and Mahtani, K. R. (2021) 'Understanding the role of the paramedic in primary care: a realist review', *BMC Medicine,* 19(1), pp. 145.

UK, *Equality Act* (2010)c.15) The National Archives.

Foster, D. (2024) *Adult social care workforce in England* Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-9615/ (Accessed: 26.02.24).

Foundations (2024) *Means Test Calculator*. Available at: https://www.foundations.uk.com/guides/process-a-dfg/means-test-calculator/ (Accessed: 05.02.24).

Guyatt, C. (2022) *AHP supporting Integration*. Available at: https://www.hee.nhs.uk/our-work/allied-health-professions/enable-workforce/ahps-supporting-integration (Accessed: 12.07.23).

The Health and Care Act (2022)(c 31) National Archives (online)

Health and Safety at Work Act (1974) legislation.gov.uk.

Health Education England (2021) *Working differently together: Progressing a one workforce approach*: www.hee.nhs.uk. Available at: https://www.hee.nhs.uk/sites/default/files/documents/HEE_MDT_Toolkit_V1.1.pdf (Accessed: 05.02.24).

Health Education England (2023) *Paramedic*. www.hee.nhs.uk. Available at: https://www.hee.nhs.uk/our-work/allied-health-professions/paramedic#:~:text=Paramedics%20can%20be%20the%20eyes,to%20support%20management%20at%20home.

Housing Grants, Construction and Regeneration Act (1996)(c.53).

Housing Lin (2024) *Occupational Therapists: Helping to get the housing design right*. Available at: https://www.housinglin.org.uk/Topics/browse/Design-building/occupational-therapy/ (Accessed: 05.03.24).

In Control (2024) *Social Care Future*. uk. Available at: https://in-control.org.uk/people-families-communities/national-network-social-care-future/ (Accessed: 29.01.24).

Kings fund (2024) *Health inequalities in a nutshell*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/health-inequalities-nutshell#:~:text=Worse%20health%20outcomes%20occur%20when,%2C%20transport%2C%20education%20and%20work. (Accessed: 05.02.24).

LGA (2023a) *Diverse by design*. Available at: https://www.local.gov.uk/our-support/workforce-and-hr-support/equality-diversity-and-inclusion-workforce/diverse-design (Accessed: 05.02.24).

LGA (2023b) *Our vision for a future care workforce strategy*. Available at: https://www.local.gov.uk/our-support/partners-care-and-health/adult-social-care-workforce/our-vision-future-care-workforce (Accessed: 05.02.24).

Local Government Association (2018) *The Standards for employers of public health teams in England*. Available at: https://www.local.gov.uk/publications/standards-employers-public-health-teams-england.

Local Government Association (2020) *The Standards for employers of social workers in England 2020*. Available at: https://www.local.gov.uk/our-support/workforce-and-hr-support/social-workers/standards-employers-social-workers-england-2020.

Local Government Association (2023) *The LGA Standards for Employers of Occupational Therapists in England 2022-2023*. Available at: https://www.local.gov.uk/our-support/workforce-and-hr-support/social-workers/national-summary-employer-standards#introduction.

Mackintosh, S., Smith, P., Garrett, H., Davidson, M., Morgan, G. and Russell, R. (2018) *Disabled Facilities Grant and other adaptations: external review*, UK: Ministry of Housing, Communities & Local Government. Available at: https://www.gov.uk/government/publications/disabled-facilities-grant-and-other-adaptations-external-review.

Medicines and Healthcare products Regulatory Agency (2023) *Bed rails: management and safe use. Guidance on managing and using bed rails safely.*, uk: www.gov.uk. Available at: https://www.gov.uk/guidance/bed-rails-management-and-safe-use (Accessed: 09.09.23).

NHS (2019) *NHS Long Term Plan*. Available at: https://www.longtermplan.nhs.uk/.

NHS England (2022a) *The Allied Health Professions (AHP) Strategy for England: 2022 §to 2027 AHP` s Deliver*. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/06/allied-health-professions-strategy-for-england-ahps-deliver.pdf (Accessed: 01.12.23).

NHS England (2022b) *Chief allied health professionals handbook*: www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/chief-allied-health-professionals-handbook/ (Accessed: 05.02.24).

NHS England (2023) *The NHS Long Term Workforce Plan* Available at: https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/.

NHS England (2024a) *Integrated Care Systems*. UK: www.england.nhs.uk. Available at: https://www.england.nhs.uk/integratedcare/ (Accessed: 25.01.24.

NHS England (2024b) *The journey to integrated care systems*: www.england.nhs.uk. Available at: https://www.england.nhs.uk/integratedcare/what-is-integrated-care/the-journey-to-integrated-care-systems/ (Accessed: 25.01.24).

NHS England (2024d) *A new community rehabilitation and reablement model good practice guidance for integrated care boards (commissioners and providers)*, UK: www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/a-community-rehabilitation-and-reablement-model/ (Accessed: 12.12.23).

NHS England (2024e) *Evolving to meet a changing world* UK: www.england.nhs.uk. Available at: https://www.england.nhs.uk/future-of-human-resources-and-organisational-development/the-future-of-nhs-human-resources-and-organisational-development-report/evolving-to-meet-a-changing-world/#:~:text=People%20are%20living%20longer%20and,more%20individuals%20managing%20multiple%20conditions. (Accessed: 26.02.24).

NHS England (2024f) *E Learning for Health Care* www.e-lfh.org.uk. Available at: https://www.e-lfh.org.uk/programmes/ (Accessed: 25.01.24).

NHS Professionals (2024) *Allied Health Professionals, Healthcare Scientists and Social Workers*. Available at: https://www.nhsprofessionals.nhs.uk/campaigns/ahp-hub.

NIHR (2023) *Study to use music therapy to reduce distress in dementia wards*: www.nihr.ac.uk. Available at: https://www.nihr.ac.uk/news/study-to-use-music-therapy-to-reduce-distress-in-dementia-wards/33822/?source=chainmail.

Office for Health Improvement and Disparities (2023) *Supporting the public health nursing workforce: employer guidance*: www.gov.uk. Available at: https://www.gov.uk/government/publications/supporting-the-public-health-nursing-workforce-employer-guidance/supporting-the-public-health-nursing-workforce-employer-guidance.

Public Health England (2018) *Improving health and care through the home: MoU*. Policy paper. UK: www.gov.uk. Available at: https://www.gov.uk/government/publications/improving-health-and-care-through-the-home-mou (Accessed: 03.01.24).

RCOT (2021d) *Principal occupational therapists in adult social care services in England: Roles and responsibilities*, UK: www.rcot.co.uk. Available at: https://www.rcot.co.uk/sites/default/files/Principal%20Occupational%20Therapists%20in%20Adult%20Social%20Care%20Services.pdf.

RCOT (2023) *Occupational therapy under pressure: workforce findings survey 2022-2023*. Available at: https://www.rcot.co.uk/practice-resources/workforce-survey-report-2023 (Accessed: 01.12.23).

RCOT (2024a) *Guidance on returning to practice in occupational therapy*. Available at: https://www.rcot.co.uk/node/35/ (Accessed: 05.02.24).

RCOT (2024b) *Equality, diversity and belonging*, www.rcot.co.uk. Available at: https://www.rcot.co.uk/equity-diversity-and-belonging (Accessed: 02.02.24).

RCOT (2024c) Workforce Strategy www.rcot.co.uk available at: https://www.rcot.co.uk/workforce-strategy Accesed on: 22.03.24.

The Regulatory Reform (Housing Assistance) (England and Wales) Order (2002).

Royal College of Nursing (2021) *Nursing Workforce Standards: supporting a safe and effective nursing workforce*. Available at: https://www.rcn.org.uk/Professional-Development/publications/rcn-workforce-standards-uk-pub-009681.

Skills for Care (2019) *Learning and development framework for occupational therapists* UK: www.skillsforcare.org.uk. Available at: https://www.skillsforcare.org.uk/resources/documents/Regulated-professions/Occupational-therapy/Learning-and-development-framework-for-occupational-therapists.pdf (Accessed: 05.02.24).

Skills for Care (2023) *The State of the Adult Care Workforce*. Adult Social Care Workforce Data. Available at: https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-State-of-the-Adult-Social-Care-Sector-and-Workforce-2023.pdf.

Skills for Care (2024a) *A workforce strategy for adult social care*. Available at: https://www.skillsforcare.org.uk/About-us/A-workforce-strategy-for-adult-social-care.aspx.

Telford and Wrekin (2024) *Virtual House tour*. Independent Living Centre Available at: https://www.telford.gov.uk/info/20792/independent_living_centre_ilc_and_virtual_house/5264/virtual_house_tou (05.03.24).

The Kings Fund (2021) *Key facts and figures about adult social care*. Available at: https://www.kingsfund.org.uk/audio-video/key-facts-figures-adult-social-care (Accessed: 23.04.23).

UK visa and immigration (2021) *Skilled Worker visa: shortage occupations for healthcare and education*. Available at: https://www.gov.uk/government/publications/skilled-worker-visa-shortage-occupations-for-health-and-education/skilled-worker-visa-shortage-occupations-for-healthcare-and-education (Accessed: 05.02.24).

Warren and Botterly (2022) *A 'radically realistic' vision for adult social care*. Available at: https://www.kingsfund.org.uk/publications/radically-realistic-vision-adult-social-care (Accessed: 23.04.22).

West Bridgford Wire (2024) 'Nottingham City Council approves £429,000 for Adult Social Care providers'. Available at: https://westbridgfordwire.com/nottingham-city-council-approves-429000-for-adult-social-care-providers/ (Accessed: 26.02.24).
West Midlands ADASS (2022) *Memorandum of Understanding for the Provision of Agency Social* WM-ADASS. (2023) *Developing an Operating Model for a Social Care Apprenticeship Academy*, www.wm-adass.org.uk. Available at: https://www.wm-adass.org.uk/media/d2gd1wyu/social-care-apprenticeship-academy-operating-model-report-final-plus-appx.pdf (Accessed: 01.12.23).*Work Professionals into Children's Services*. Available at: https://adcs.org.uk/assets/documentation/WM_MoU_v7_July22.pdf.

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Declaration of interest

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