


# **An Investigation into the Occupational Therapy Workforce in London**



## **Report of Phase 1(Part A): Workforce Data Analysis Report on the Listening Event (Part B): The London Occupational Therapy Workforce**

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Glossary

ADASS	Association of Adult Social Services Directors
AHP	Allied Health Professions
AYSE	Assessed and Supported Year in Employment
COT	College of Occupational Therapists
CPD	Continuing Professional Development
EU	European Union
FTE	Full time Equivalent
HCPC	Health Care Professions Council
HEI	Higher Education Institution
HEESL	Health Education England south London
LSBU	London South Bank University
MH	Mental Health
NHS	National Health Service
OT	Occupational Therapy
OTA	Occupational Therapy Assistant
SLAHP	South London Allied Health Professions Forum
SS	Social Services
SW	Social Work

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## Report of Phase 1 (Part A) Workforce Data Analysis

### 1.0 Background

There is a very limited research base exploring the recruitment, retention and turnover of AHPs in general (Loan-Clarke et al, 2010, Pang et al, 2002) and, of the literature that does exist, there is little representation for the occupational therapy (OT) workforce. In 2004, the turnover rate for AHPs in Britain was 15% (Office of Manpower Statistics, 2004).

Drawing from the limited research available, it seems that AHP staff leave due to workload/ pressure, limited career prospects, family commitments, and pay (Chartered Society of Physiotherapy, 1998, Rossiter, 2000, College of Occupational Therapists, 2002). Specific reasons for leaving jobs are hard to determine but appear to be more diverse and influenced by local factors (Jenkins, 1991, Noh & Beggs, 1993, Mills & Millsteed, 2002). In 2002, Hunter and Nicol found “little evidence that provision of CPD influenced recruitment and retention of OTs” (Loan-Clarke, 2010, p392).

It would appear that recruitment and retention of allied health professionals is a complex interplay between personal, environmental and work-related factors (Mills & Millsteed, 2002).

### 2.0 Occupational Therapy Workforce in London

Recruitment and retention issues in occupational therapy have been the subject of significant concern for many years. There is a small evidence base which suggests that satisfaction, professional development opportunities, career development pathways, supervision and the positive aspects of an individual's role may impact positively on the occupational therapy workforce (Scanlan et al, 2010). It is suggested that factors leading to poor retention specific to the occupational therapy profession include lack of role definition, poorly perceived professional prestige, the negative influence of generic work, inadequate professional support or continuing education, stress, and burnout.

The HEE south London team set up an AHP network to support workforce and education planning processes, and to generate an understanding of the issues specific to the therapy professions. HEE south London have engaged through the workforce planning process and the AHP forum with a large cross section of occupational therapy service managers and various senior professionals, who provided data to help explore the following issues -

- Reported problems recruiting bands 6, 7 and 8a
- Reported problems with retention, specifically with Band 5 occupational therapists
- Reported specific recruitment, retention and workforce issues in Mental Health and Paediatrics
- Job design and lack of CPPD opportunities that could be negatively impacting this workforce
- Support for adding occupational therapy to the shortage profession immigration list

These identified issues are supported by the College of Occupational Therapists (COT) in their Partial Review of the Shortage Occupation Lists for the UK and for Scotland (COT, 2015). This report sets out the acute nature of the occupational therapy shortage for inner and outer London in both health and social care settings. There is a perception that the shortage of occupational therapists within London has become critical such that both the HEE Local Education and Training Boards in London and also the Association of Adult Social Services Directors (ADASS) London region have raised this as a matter that requires further urgent investigation.

The COT report identified that there is a real difficulty in recruiting to occupational therapy posts within the London area, which is thought to have emerged over the last few years following the removal of occupational therapists from the shortage of occupation list.

There is concern that if the shortage situation is not addressed, occupational therapy services will be insufficient for the population of London and there is a high likelihood that these posts will be lost, impacting the health and wellbeing of patients and service users and their carers in London, as well as their ability to live independently. An additional risk is the efficiencies that occupational therapists may bring through prevention services (and their associated cost savings) which would be a loss to both health and social care economies.

However, outside of the occupational therapy professional leads' feedback there is little quantitative or qualitative evidence relating to these problems and issues.

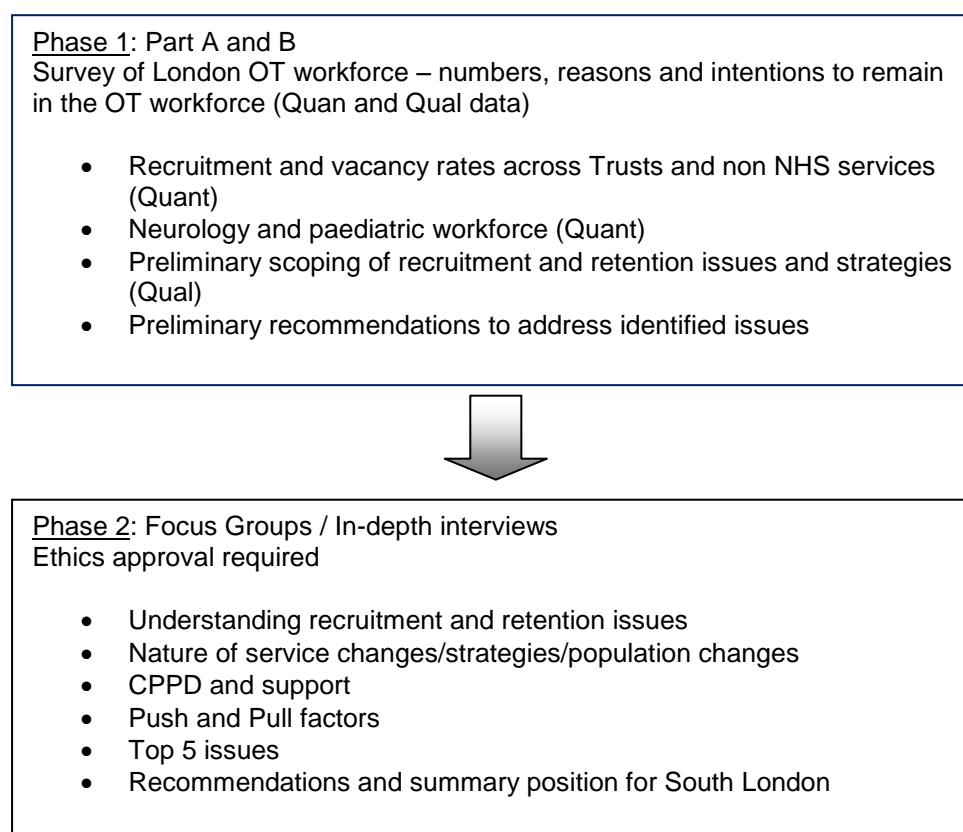
### 3.0 Occupational Therapy Workforce in London Project

In response to the reported issues with occupational therapy workforce in London, and the need to clarify the current position, the south London HEE team commissioned London South Bank University (LSBU) to carry out a project to investigate workforce data in London and to identify factors which may be contributing to the data. LSBU have formed a Project Team and have been working closely with colleagues at HEE south London and COT during the initial part of the project.

#### 3.1 Project Methodology

The project has a two-phased approach as outlined below. Phase 1 Part A is the focus of this report and relates to workforce data gathering and analysis.

| A diagrammatic overview of the project methodology is provided in **Figure 1, below**.



## Phase 1 – Part A

### Workforce Data Gathering and Analysis Phase

In this phase the data gathering was led by the HEE south London team with COT. Data templates were circulated to occupational therapy managers in NHS and Social Care settings in London from contact lists held by HEE south London and COT, and via AHP and occupational therapy network circulation lists. The data spreadsheets submitted to HEE south London were passed on to LSBU for collation and analysis.

### Data Collection Template

The data collection template was designed by HEE south London and agreed by the project team. The template was in the form of an excel spreadsheet accompanied by an email which asked occupational therapy leads in NHS and Social Care organisations to complete and return the spreadsheet to HEE south London. Responders were asked to use 31st March 2015 as a census point for this data.

The following data was requested in relation to occupational therapy staffing across all settings:

1. Establishment
2. Staff-in-Post
3. Vacancy Rate
4. Narrative space for comments on how long these vacancies have been unfilled

In addition, NHS staff data was requested by band (5-9) in the following specialities:

- Mental Health
- Learning Disability
- Orthopaedics
- Paediatrics
- Neurology
- A&E
- Elderly Care
- Medical & Surgery
- Oncology
- End of Life Care
- Cardiac and Pulmonary Heart Disease
- Re-ablement / Intermediate Care / Rehabilitation
- Other

In Social Care staff data was requested across the following areas:

- Children's Services only
- Adults Services only
- Adults & Children's Services
- Re-ablement only
- Other

In Social Care staff data was requested by the following categories:

- Occupational Therapy Practitioner
- Senior Practitioner
- Team Manager
- Service Manager

### 3.2 Data Collection Timescale

Following finalisation and agreement of the data collection template, requests for data were sent to occupational therapy leads via email initially on 1st April 2015, requesting the return of datasheets by 22nd April. In order to prompt a higher return rate a further email was circulated in late April 2015 noting an extended deadline of 8th May 2015.

As a result of feedback from south London AHP Network meetings a further email was sent out requesting a final return by 29th May 2015. Any additional datasheets submitted up until 19th June to LSBU were included to optimise the return and allow enough time from the write up of this initial part of the project.

### 3.3 Data Analysis

The spreadsheets were collated and analysed using descriptive methods. The outcomes of this phase were two-fold: firstly, to provide appropriate workforce data which could be used as the basis for annual occupational therapy workforce planning by HEE south London in July 2015; and secondly, to provide baseline data to inform the next phases of the current project.

Narrative data provided on the spreadsheet and in accompanying emails was collated.

### 3.4 Ethical Considerations

The aim of Phase 1 Part A of this project was to establish baseline occupational therapy workforce data. As a workforce evaluation project and according to guidance given by the NHS Health Research Authority (2013) Phase 1 of this project does not require ethical approval.

## 4.0 Results

### 4.1 Responders and Response Rates

Data submissions were received from 20 of 38 NHS Trusts in London (48%) and 16 of 33 Boroughs (53%) with an even spread across London regions in each category.

### 4.2 Occupational Therapy Workforce Data in London – NHS

The following analysis is based on the datasheets submitted by responders and their accompanying narrative.

#### 4.2.1 Overall London NHS Occupational Therapy Workforce

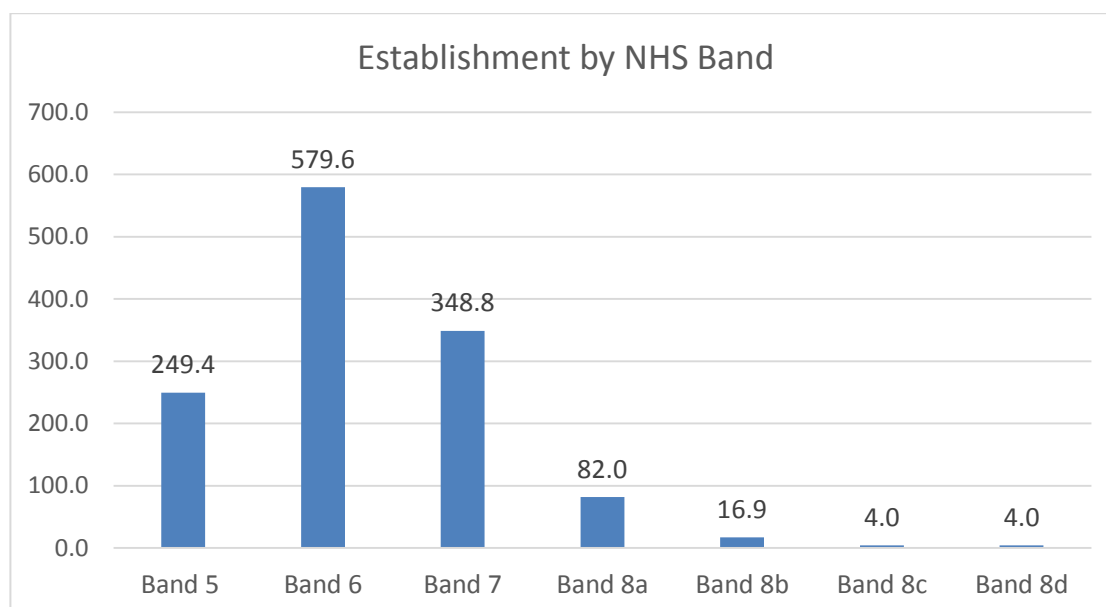
Across the 20 Trusts who submitted data, the establishment of occupational therapy staff was reported as 1285.7 FTE, with 1071.4 FTE staff in post. Vacancy FTE was reported as 199.1, resulting in a vacancy rate across the NHS Trusts of 15.5%.

#### 4.2.2 London NHS Occupational Therapy Workforce by Band

##### **a/ London NHS Occupational Therapy Establishment by Band**

The bar chart below demonstrates that the vast majority of the occupational therapy workforce establishment across the NHS is at Band 5-7, peaking at Band 6 with 579.6 FTE. Only 4 FTE were reported at Band 8c and 8d respectively.

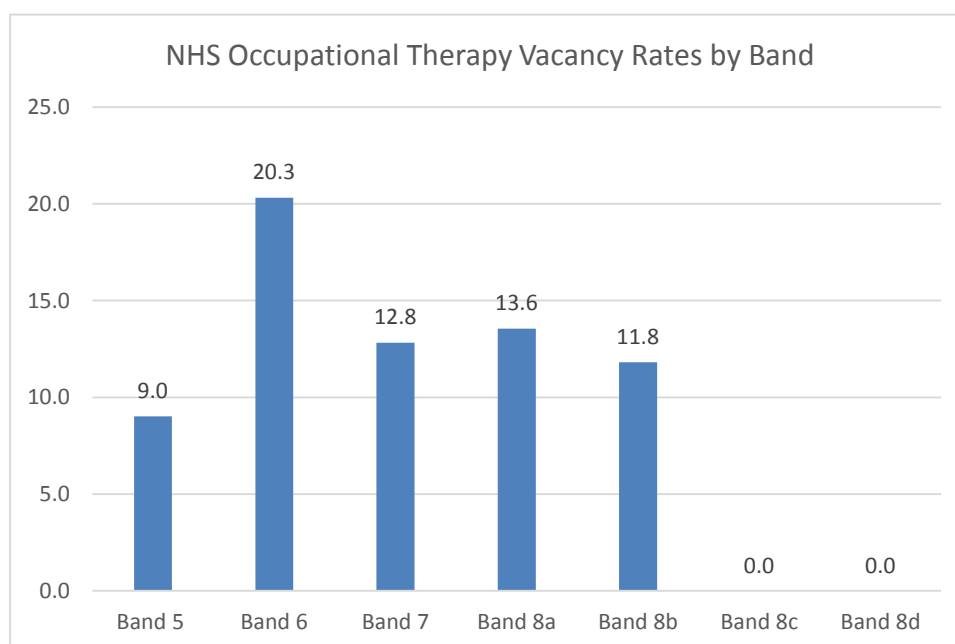




**Figure 2: London NHS Occupational Therapy Establishment**

**b/ London NHS Occupational Therapy Vacancy Rates by Band**

Occupational therapy vacancy rates at ranged from 9.0% at Band 5 to 0.0% at Band 8d, peaking at 20.3% at Band 6. The vacancy rate at Band 6 is of concern since this is the largest occupational therapy staff group in the NHS and it accounts for 117 FTE vacancies.

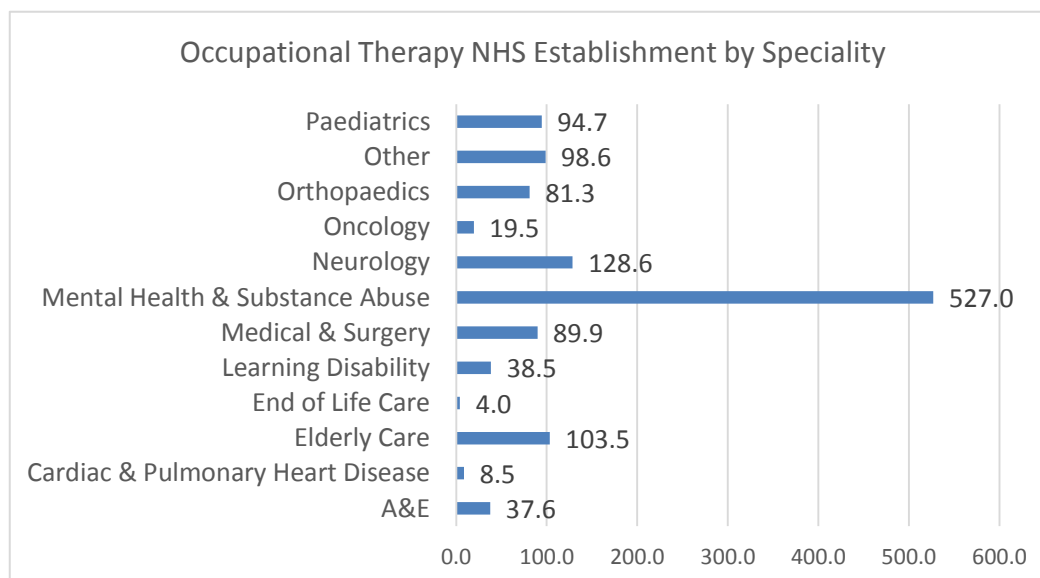


**Figure 3: NHS Occupational Therapy (%) Vacancy Rate by Band**

**c/ London NHS Occupational Therapy Establishment by Speciality**

The vast majority of the reported establishment is in Mental Health Occupational Therapy (526 FTE). This does reflect the specialist nature of some of the key Trusts who returned data, but nonetheless demonstrates the high demand for occupational therapists with appropriate knowledge and skills in this field.

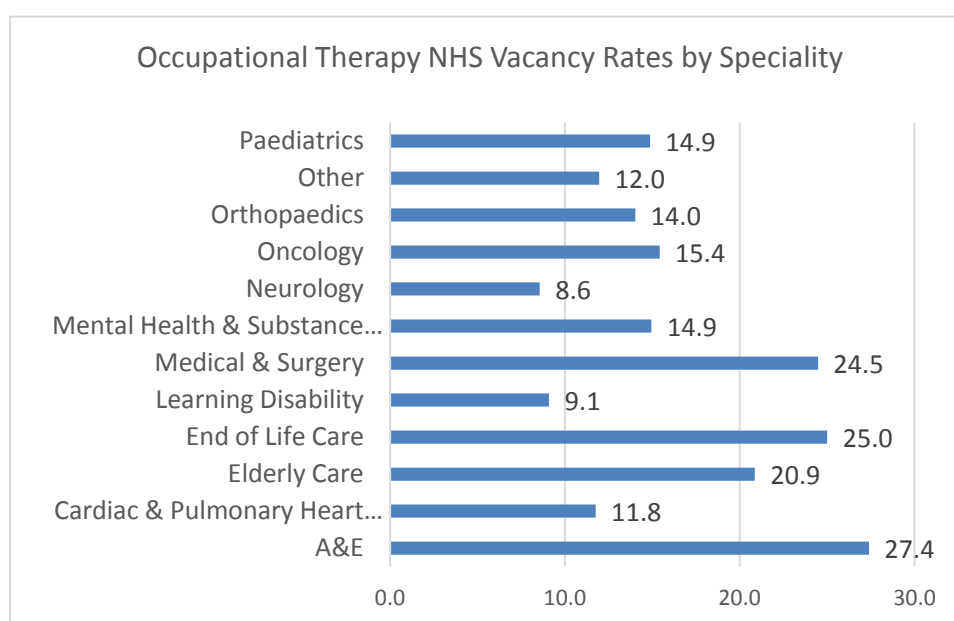
The accompanying narrative highlighted the fact that Cardiac and Pulmonary Heart Disease is often considered as part of Medicine, and that End of Life Care rarely has a designated service but is part of other services relating to Oncology or Medicine. The 'Other' category often included specialist services relating to Hand Therapy, Burn and Plastics, Trauma, Wheelchair Service or Community Services where these were funded by the Trust.



**Figure 4: NHS Occupational Therapy Establishment by Speciality**

#### d/ London NHS Occupational Therapy Vacancy Rate by Speciality

As can be seen in Figure 5 below, NHS Occupational Therapy Vacancy rates range from between 11.8% in Cardiac and Pulmonary / End of Life Care to 27.4% in A and E. However, in terms of substantive numbers of vacancies, the 14.9% vacancy rate in Mental Health occupational therapy as the largest working group represents 78.8 FTE vacancies.



**Figure 5: NHS Occupational Therapy Vacancy Rate (%) by Speciality**

### e/ London NHS Vacancy by Speciality and Band

Table 1 below lists the specialities by band where the vacancy rates are over 20% as reported NHS occupational therapy workforce data returns for this project. These are presented where there is a minimum establishment of 10 FTE across the workforce since differences in the baseline establishment will affect overall vacancy rates significantly. The impact on the individual departments is not clear and this may vary significantly. The narrative provided for a large Trust for instance stated that Band 6 in Mental Health is the most difficult to recruit to. In real terms, however, it was reported that the impact of the vacancy rate is lessened by the fact that occupational therapists are also employed in more generic care worker roles which fall outside of occupational therapy establishment. There is also supporting narrative for difficulty recruiting to posts in paediatrics in particular.

Speciality	Band	Establishment	Post	Vacancies	Vacancy Rate %
Medical & Surgery	6	31.0	18.0	13.0	41.9
A & E	6	18.6	11.6	7.0	37.6
Elderly Care	6	34.2	21.6	12.6	36.8
Orthopaedics	6	31.5	22.5	9.0	28.6
Other	8a	10.8	7.7	3.0	27.9
Paediatrics	8a	14.8	10.8	4.0	27.1
A&E	7	13.3	10.0	3.3	24.8
Reablement	6	20.9	15.9	5.0	23.9
Medical & Surgery	7	18.8	14.8	4.0	21.3

**Table 1: Vacancy Rates over 20% by Speciality and Band in decreasing order of % Vacancy Rates**

## 4.3 Occupational Therapy Workforce Data in London – Social Care

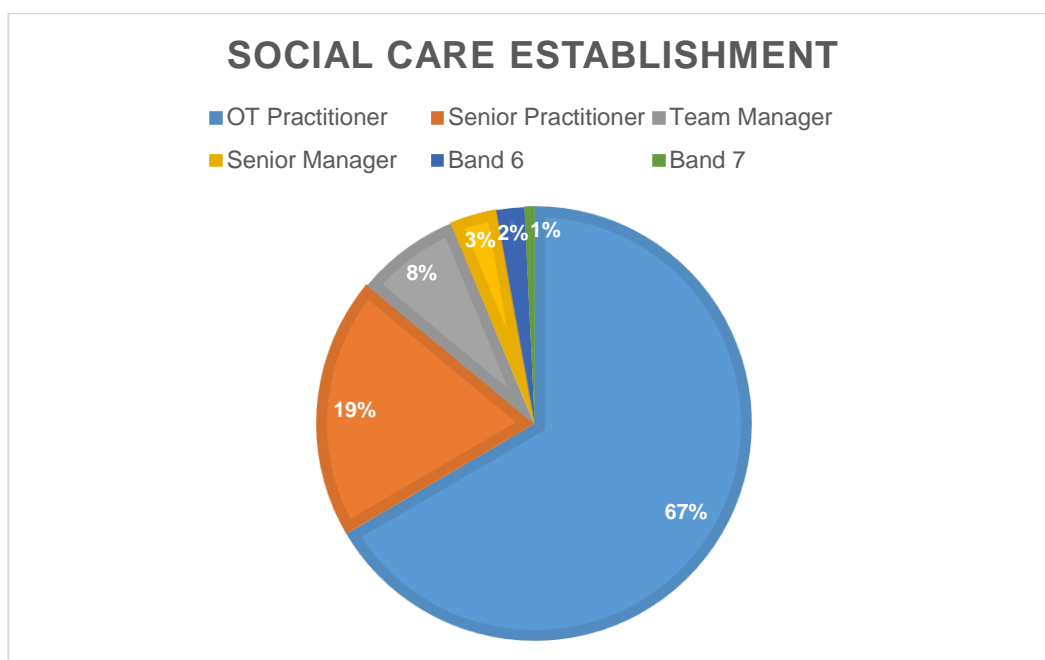
### 4.3.1 Overall London Social Care Occupational Therapy Workforce

Across the 16 Boroughs who submitted data, the establishment of occupational therapy staff was reported as 297.9 FTE, with 246 FTE staff in post. Vacancy FTE was reported as 52.0, resulting in a vacancy rate across the Boroughs of 17.5%.

### 4.3.2 London Social Care Occupational Therapy Workforce by Role

#### a/ London Social Care Occupational Therapy Establishment by Role

The pie chart below demonstrates the vast majority of the workforce establishment across Social Care is at OT Practitioner level. In one Borough workforce at Band 6 and Band 7 was reported as mixed NHS / Social Care Roles in Re-ablement / Integrated Care.



**Figure 6: London Occupational Therapy Establishment in Social Care**

**b/ London Social Care Occupational Therapy Vacancy Rates by Role**

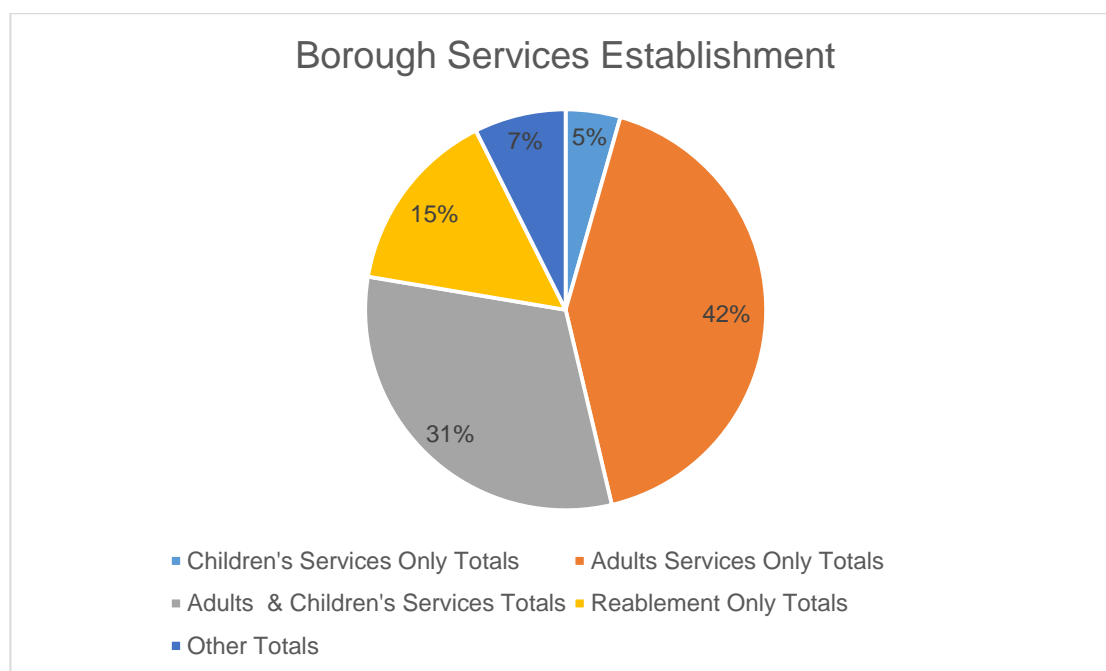
Occupational therapy social care vacancy rates are reported as 0 to 50%. In the more traditional roles vacancy ranges from 9.5% to 18.2% - see Table 2 below. The vacancy rate at OT Practitioner level is the highest. In this largest OT staff group reported in Social Care this accounts for 36 FTE vacancies.

Roles	Establishment	Vacancies	Vacancy Rate %
OT Practitioner	198.2	36.0	18.2
Senior Practitioner	58.0	9.0	15.5
Team Manager	23.0	3.0	13.0
Senior Manager	10.5	1.0	9.5
Band 6	6.0	3.0	50.0
Band 7	2.1	0.0	0.0
Totals	297.9	52.0	17.5

**Table 2: London Social Care Occupational Therapy Vacancy Rates by Establishment**

**c/ London Social Care Occupational Therapy Establishment by Service**

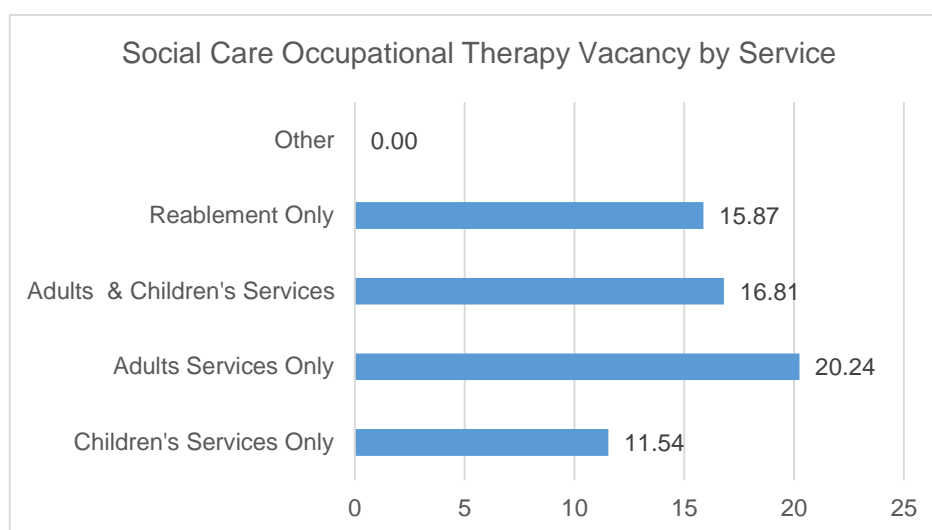
Figure 7 below illustrates the two main service areas reported as Adult Services (42%) and combined Adults and Children's Services (31%), followed by Re-ablement (15%), Other (7%), and Children's Services (5%). The Services on the 'Other' category were reported to include Housing, Repairs and Adaptation, Telecare, and Assessment and Intervention.



**Figure 7: London Social Care Occupational Therapy Establishment by Service**

#### **d/ London Social Care Occupational Therapy Vacancy Rate by Service**

As can be seen in Figure 8, the vacancy rates across the key reported services range from 11.5% to 20.2%. These fall into areas of higher occupational therapy establishment.



**Figure 8: London Social Care Occupational Therapy Vacancy Rate % by Service**

#### **e/ London NHS Vacancy by Service and Role**

The highest 10 vacancy rate % per service and role are listed in Table 3 below. This demonstrates the potential impact of a high vacancy rates at OT Practitioner level in Adults / Adults and Children's services. The supporting narrative provided by responders highlights the difficulties in recruiting these occupational therapy practitioner roles and an on-going need to make use of locum staff to maintain service levels. In some cases, lower vacancy rates were reported due to use of locums, suggesting that vacancy rates to permanent roles may be under-reported.

Service	Role	Establishment	Post	Vacancy	Vacancy %
Adults & Children's Services	Senior Manager	3.0	3.0	1.00	33.3
Adults & Children's Services	Team Manager	8.0	6.0	2.00	25.0
Adults Services Only	Senior Practitioner	22.5	17.5	5.00	22.2
Adults Services Only	OT Practitioner	87.0	70.0	19.0	21.8
Reablement Only	OT Practitioner	28.0	22.3	5.5	19.6
Reablement Only	Senior Practitioner	8.0	6.5	1.5	18.8
Adults & Children's Services	OT Practitioner	65.4	51.3	11.5	17.7
Adults Services Only	Team Manager	11.0	10.0	1.0	9.1
Adults & Children's Services	Senior Practitioner	16.0	15.0	1.0	6.2
Children's Services Only	OT Practitioner	7.0	7.0	0.0	0.0

**Table 3: London Social Care Occupational Therapy Highest 10 Vacancy Rate % by Service and Role, highlighting numerical vacancies over 10 FTE**

#### 4.4 Data Limitations

While this dataset represents a large number of occupational therapists and services, there are many and notable exceptions. As such data is therefore only inferred from the results gained here.

In addition, the data was provided at a census point on 31st March 2015. This provides a useful snapshot of information which can be helpful with immediate occupational therapy workforce planning needs; however it does not take account of trends or historical data. The use of locums in terms of occupational therapy vacancy and its reporting was not always clear from the narrative provided.

Finally, many of the spreadsheets were incomplete in parts. However, in the majority of cases the omissions seemed obvious, for instance failing to include numbers in post when the establishment and vacant posts were completed.

#### 4.5 Conclusion and Next Steps

This initial part of the commissioned project involved the requesting and gathering of occupational therapy workforce data across London-based NHS and Social Care providers. Returns were received from approximately 50% of NHS Trusts and Boroughs. NHS Trust vacancy rate for occupational therapy based on this data is 15.5% and in Social Care the vacancy rate is 17.5% overall.

The majority of the occupational therapy vacancies and highest occupational therapy vacancy rates in terms of role is at Band 6 in the NHS (20.3% vacancy) and OT Practitioner in Social Care (18.2%). These substantial vacancy rates are supported by a narrative describing difficulty in recruiting staff at this level. There may be other factors which impact upon vacancy rates such as the use of locums.

The highest vacancy rate from NHS data in terms of speciality was in acute care (Medical and Surgical, A&E), but the most numerous were where the establishment is highest, in Mental Health. In Social Care occupational therapy highest vacancy rates are in Adult and Children's / Adult Services and most significant at OT Practitioner level.

Part A, the bulk of the project, has concentrated on the analysis and interrogation of workforce data. The next section of the report presents some preliminary findings generated through a Listening Event hosted by the College of Occupational Therapists.

## 5.0 Report on Part B The Listening Event:

### **The London Occupational Therapy Workforce**

**hosted by**

**The College of Occupational Therapists**

**Tuesday 7<sup>th</sup> June 2016**

### 5.1 Introduction

Phase One of the project surveyed the Occupational Therapy London Workforce to gather and analyse data on recruitment and vacancy rates across NHS and non-NHS services. The outcomes of Phase One were presented and discussed at the Listening Event. Phase Two of the project proposed to run focus groups for all bands of occupational therapists but recruitment to the focus groups has proved problematic. It was decided that offering an opportunity for occupational therapists to come together to discuss and share their experiences and perceptions of the problems behind retention and attrition in London may be a fruitful way forward before moving towards a more in-depth approach.

The Listening Event was identified as a way to report on the outcomes of Phase One of the study and to bring together practitioners, from all bands and across all work settings, for an opportunity listen to each other's perspectives on the workforce in London. The event also aimed to prioritise key workforce issues for dissemination to commissioners, COT and HEIs.

An important part of this event in bringing together practitioners was to explore how recruitment and retention of the occupational therapy workforce in London could be understood and improved. The event was organised by LSBU and the College of Occupational Therapists who invited occupational therapists across London, from newly qualified to senior managers, to discuss their experiences of working as occupational therapists in London. Attendees were facilitated to discuss the London situation from a number of perspectives such as job satisfaction and factors dissuading or encouraging people to work within the NHS, SS or wider organisations.

We would like to thank COT for hosting the event, all of those London based occupational therapists who took part in the event and the managers who released them for the day. We would like to thank Dr Sally Beckwith, Cheryl Angell-Wells, Anne Marie Langan, Janet Parker, Dr Stephanie Tempest and Professor Lesley Haig who facilitated the discussion groups and submitted reports on the outcomes of these. We are also very grateful to all of those occupational therapists who returned surveys for Phase One of the project and COT, LSBU and HEE south London for funding the Occupational Therapy Workforce Project.

### 5.2 Background

The College of Occupational Therapists (COT) reported on their Partial Review of the Shortage Occupation Lists for the UK and for Scotland through its Migration Advisory Committee (COT, 2015). This report set out the acute nature of the occupational therapy shortage for inner and outer London in both health and social care settings. There is a perception that the shortage of occupational therapists within London has become critical such that both HEE south London and the Association of Adult Social Services Directors (ADASS) London region have raised this as a matter that requires further urgent investigation.

The Migration Advisory report (COT, 2015) identified that there is a real difficulty in recruiting to occupational therapy posts within the London area, which is thought to have emerged over the last few

years following the removal of occupational therapists from the shortage of occupation list. Anecdotally many of the London posts had been filled in the past (when occupational therapists/occupational therapy was on the shortage of occupation list) by occupational therapists from; Australia, New Zealand, South Africa, Canada and the United States.

There is concern that if the shortage situation is not addressed, the risk is that occupational therapy will not be available to the population of London as these posts will inevitably be lost. The loss of these posts may impact the health, wellbeing and the ability to live independently of patients, service users and their carers in London. An additional risk is the cost efficiencies that occupational therapists bring through prevention services will be a loss to both health and social care economies.

Following meetings with lead occupational therapists in acute, community and mental health settings in London and a survey commissioned by the ADASS London Region, reasons for difficulty in recruitment include:

- Cost of living in London and cost of travel into London
- Occupational therapists are a largely female workforce, however Trusts reported that flexible working/job-share or part-time were rarely offered which added to the recruitment problem
- High turnover of Band 5 staff
- Lack of opportunities for career progression
- Time available from senior staff was limited to support new graduates
- Recruitment advertising is limited due to costs
- In the past a large number of these posts would have been filled by international occupational therapists
- Difficulty in offering temporary support worker contracts for occupational therapists wishing to return to practice. It is a requirement from the HCPC that depending on the length of time not on the HCPC register, a period of between 30-60 days supervised practice is needed as part of the HCPC Return to Practice requirement
- There are two HEI universities in London offering occupational therapy degrees. Part of the curriculum requires student placements within occupational therapy services under the supervision of an occupational therapist. Due to the shortage of occupational therapists placements have been restricted. Successful placements have traditionally been a way of recruiting new graduates.

The Migration Advisory Committee report (COT, 2015) describes ways in which London Trusts and Boroughs have tried to recruit to occupational therapy posts with little success. Lack of recruitment has led to the employment of expensive locum staff. Further, the Migration Advisory Committee report (COT, 2015) suggests that the specialist areas of greatest demand for occupational therapists are A&E and Mental Health with a prediction that more occupational therapists will be needed within community and social care settings in London.

HEE south London have engaged through the workforce planning process and the South London AHP forum with a large cross section of occupational therapy service managers and various senior professionals. Through this engagement process various issues for the Occupational Therapy profession have been raised, these include;

- Problems recruiting bands 6, 7 and 8a
- Once recruited there is a problem with retention, often Band 5s do not stay long enough to be developed into a band 6
- Specific issues in Mental Health and Paediatrics
- Job design and lack of CPD opportunities could be negatively impacting this workforce



- Support for adding occupational therapy to the shortage profession immigration list

These identified issues are supported by research undertaken by the College of Occupational Therapists (COT, 2015). However, outside of the occupational therapy London leads' feedback, there is little quantitative or qualitative evidence of these problems and issues.

The Listening Event commenced with an overview of the report from Phase One of the study, the Workforce Data Analysis, presented by Professor Lesley Haig. The report found that the majority of the occupational therapy vacancies and the highest occupational therapy vacancy rates in terms of role is at Band 6 in the NHS (19.4% vacancy) and occupational therapy practitioner in Social Care (18.2%).

What follows next is a summary of the main points to have emerged from the day, firstly by top priorities for each Band and secondly by narrative description of themes to have emerged from the round table discussions.

The report closes with some suggestions to address retention and attrition that emerged from the day that will be taken forward to shape the second phase of the Occupational Therapy Workforce Project.

### 5.3 Top Four Priorities by Band

The top priorities were generated through facilitated groups, which were organised by Band. Following in-depth discussion of perceptions of workforce issues, each group displayed their Band's ideas on large sheets of paper, identifying their top three priorities. All participants then viewed all of the sheets. Following the viewing of all of the sheets, each individual had 5 dots to 'spend' in accordance with their perceived top priorities. The 'spend' could be outside of their own Band's priorities.

Totals were then summarized for each Band's sheet to give the total spend per Band as outlined next;

#### **Band 5**

- Transition from University to first job (5)
- Early induction is important, shadowing, professional guidance (e.g. what assessments to use to part of the wider team/link to whole Trust) (5)
- Multiple roles – Activity co-ordinator, volunteer co-ordinator, 1<sup>st</sup> job (2)
- Range/balance of placements important experience

#### **Band 6**

- Flexibility – terms and conditions (e.g. job shares, contracts, P/T) (13)
- Expectations vs reality (4)
- Less invested in you as a Band 6 – forgotten (3)
- Training, development and support (3)

#### **Band 7**

- Causes – Locums – up money to invest in permanent staff. Recognition of hard work (11)
- Where are all the occupational therapists? – they are locums (2)
- What might we do to stop it – senior management support, support structure, the team (4)
- What might we do to stop it – need more Band 5 posts available in paediatric Occupational Therapy /offering training and education (2)

#### **Band 8**

- Occupational Therapy training – graduates are not equipped to deal with what they were trained to do (7)
- Graduates are not prepared for work (4)
- Is 3 years training sufficient to be dual trained occupational therapists? (4)
- Complexity and change (3)

### **Boroughs/Social Services**

- Locum salary vs permanent salary (9)
- Drop in pay comparative to NHS (8)
- Flexibility of working hours (4)
- Shared and social care rotations (2)

Following the Dot Spend, the totals were then integrated with the narrative findings from the facilitated groups, which is presented in the next section of the report.

### **5.4 Summary of narrative findings from the facilitated groups**

Factors impacting the shortage of occupational therapists in London fall into the following six areas;

- Impact of the locum situation in London
- Transition into the workforce and retention strategies
- Career progression
- Working environment and flexibility of working practices
- High cost of living
- Perceived problems with recruiting to and retaining occupational therapists - is there a particular problem in Mental Health and Paediatrics?

### **5.5 Impact of the locum situation in London**

The Band 6 group recounted numerous examples of colleagues that had left permanent positions and returned to the same service in a locum capacity almost immediately. The fact that locum staff received higher pay rates in conjunction with less responsibility i.e. locums are not required to supervise other staff and/or students, was perceived as a reason to move on from a post.

The impact of locum employment was described as a demand on Band 7 time for induction, additional administration, demand on time for supervision, extra work stress to train them which decreases the level of support for junior support and then they can leave with 1 weeks' notice. The consequences of this are that Band 5s do not see 'what a great Band 6 does' which may lead to them thinking that they are ready for a Band 6 post too early. The Band 5 group did not raise the issue of locum employment but suggested that there was little time for support from the Band 6 occupational therapists and felt their role was 'unprotected' by senior staff. There is a perception that locums have increased flexibility - Band 6 suggested that finances are challenging "and then you see people leave to locum who have more money and more flexibility so it looks like an attractive option".

The Band 7 group felt that many Band 6 and 7s decided to work as locums as this offered better financial rewards. They reported that new graduates were also following the locum path driven by promotion desires. In their opinion, this locum route was taken too early e.g. 1 year in practice and despite the graduate practitioner lacking confidence and work experience for the role. The situation was perceived as very unfair on permanent staff who invested time and energy in educating locum practitioners (which they did see as part of their clinical role) only for them to leave. The often swift departure of locum staff placed pressure on Band 5 and 6 practitioners who were required to cover the departed locum's work. As a consequence Band 5s were sometimes being asked to take on roles that they were not yet ready for, for example, performance managing other staff. This was felt to be a different earlier career experience to that of the members of the Band 7 group. The group felt that this situation was not beneficial for Band 5s especially if they received minimal supervision and could result in disillusionment and exiting the profession. The lack of locum accountability was therefore an area of high concern. It was perceived that service users also feel the brunt of the transient staffing situation.

The Band 8 group felt that the advantages to be gained by locum positions in terms of financial advantage and flexible working patterns outweighed other potential NHS work-related advantages (e.g. pension, peer support, support for CPD).

From the Boroughs' perspective, the majority of teams use and depend on locums and will employ the same locum for the long term. One manager stated that she felt it did not cost more to employ a locum when pension, holiday and sick pay are taken into consideration. This group also felt that the locum market had changed dramatically, with many more agencies and a higher rate of commission for agencies in the NHS than in social care.

There is also the suggestion that economic drivers encourage practitioners to take the locum route, particularly in London.

### **5.6 Impact of locum use - Key points:**

- Permanent Band 5 and 6 clinicians were suffering because of high locum usage and turnover; investing energy in educating locums was misplaced and more should be done for permanent staff (it was believed that locums from other countries will eventually go home);
- For Band 6 clinicians the locum situation could be perceived as instrumental in taking the decision to leave a job;
- It is tempting to also choose to locum;
- Loss of a supportive hierarchical team structure for modelling professional behaviours and resulting in gaps in practical skills;
- Educational investment in locum staff is lost to the service and they do not normally contribute to service development;
- Locum use has become normalized as a professional progression route.

### **5.7 Preliminary suggestions to address impact of locum use:**

- Better support for Band 5s;
- Reduce usage of locums or treat them like staff so that they become staff (increase accountability);
- Invest more in the permanent staff;
- More training and support is needed for permanent staff so it looks more attractive to remain rather than to locum;
- Promotion only when someone is ready;
- Good leadership is essential.

The impact of locum use and the listed suggestions to address them are preliminary. Literature on themes known to impact the occupational therapy workforce (e.g. Scanlon et al, 2010) does not feature in the impact of locum use. This may suggest that the impact of locum use on the occupational therapy workforce is particularly acute or unique to London or reflects the rise in the numbers of occupational therapists choosing to locum as a professional career route (normalisation effect).

### **5.8 Transition into the workforce and retention strategies**

Band 8 participants expressed a view that on graduation students lack preparedness for practice; from knowledge and skills to confidence and not being employable on graduation. This, they suggested, was in stark contrast to newly qualified staff arriving from Australia and South Africa who they perceived to be more proficient. This may be due to the nature and length of their courses. Variation across HEIs was noted. It was queried whether entry criteria and ways to ensure good academic and occupational therapy related characteristics were sufficient. Group members stated that they would value being more involved in and contribute to training/courses.

Band 5 participants reported that transition into the London workforce was driven by a number of factors including personal connections or a positive final placement experience. Perceptions that working in London would provide them with a modern career with a variety of jobs in a range of sectors and a good social life did not always turn out to be the reality (loneliness is reported). They reported that longer term career planning at this early career point feels too far away for them. Band 5 participants expressed concerns as to whether they had made the right first job choice as they perceived there was too much generic working, insufficient occupational therapy focus to their practice (e.g. selecting and training volunteers, supervising occupational therapy assistants [OTAs]), whilst being expected to undertake duties beyond Band 5 with little supervision. Band 5s expressed concerns about being led and managed by non-occupational therapists. An interesting point was raised with regard to how a delay in HCPC registration 'tempts' new graduates to look for employment outside of London where employers are perceived to be more prepared to employ them at Band 4 until their HCPC registration is confirmed. Moreover, it is reported that as competition for jobs in London is high anybody who is not HCPC registered at the time of application is not shortlisted. This practice may push new graduates out of London for their first jobs.

Interestingly, the Band 6 group perceived that Band 5 occupational therapists receive significant support and development opportunities under Preceptorship Programmes and Band 7 occupational therapists have opportunities to develop supervisory and managerial skills. Regarding development opportunities for Band 6 staff, the group posed the question "where do we come in, among all the demands of caseload, staff supervision and students". The Band 6s felt that they are generally expected to identify creative ways to address their own learning needs within services and feel like 'work horses' in their roles.

There was a general perception that services expected Band 6 staff to undertake the majority of clinical care (when compared with other grades) in addition to the supervision and training of more junior staff, support staff and students. At the same time it was perceived that services invested less in the development of Band 6 occupational therapists and that they had fewer opportunities to access training when compared with other grades.

Band 6 participants discussed the attractions of working in London, including; being closer to family; experience working in new and different environments, accessing varied and diverse rotations and a perception of greater exposure to new and innovative ideas. Whilst this perception attracted therapists to London it also appeared to play a role in decisions to move out of London i.e. there was a fear that moving out of London would impact opportunities to be involved in new and innovative practice. There was potential for greater opportunity, professional development and progression within London when compared to areas outside London; the perceived challenge that "if you can work in London, you can work anywhere" was attractive for some.

With regards to **retention strategies**, the Band 8 group felt that it was vital to make sure that staff feel valued and supported. If staff feel valued they may be more likely to stay in the service or return to an employer in due course. There is a suggestion that Band 8s struggle to recruit suitable staff due to recruitment practices not being sufficiently robust to differentiate between more or less capable staff. There is a sense that the organisation may force this group to be too generic and they lack confidence to be able to challenge this practice. Opportunities to share experiences would help them to hear about practices elsewhere (networking?).

The Band 8 group suggested that retention strategies are not fit for purpose, they look at why people leave jobs rather than reasons for staying.

The Band 6 group identified that the profession specific and MDT teams in which they worked were a significant factor to stay in post. Rotational posts are valued but the value of the necessity to complete some rotations, perceived as less attractive, in order to access more specialist rotations, was questioned. Band 6 participants expressed a fear of moving outside the occupational therapy team structure and the support of the NHS due to potential impact on career progression and supports available. Opportunities to contribute to and shape service developments would be valued.

### 5.9 Preliminary suggestions to address retention:

- Need to promote networks in London
- Need to ensure retention strategies are fit for purpose
- Need to ensure that all grades of staff feel valued and included in service developments
- Consider whether COT Regional Groups can be part of the solution in supporting the networking and learning around interview and recruitment issues

#### **Career progression**

There is a suggestion that after Band 7 jobs are management based and that this is not for everyone. There is a suggestion to increase and widen the remit of 8a posts within the NHS to create different career paths and to retain staff with high quality clinical skills (e.g. link with universities and have roles that are joint funded as lecturers and research leads). This would also increase the development of the evidence base for occupational therapy (paediatrics). For the boroughs, fewer opportunities are offered and, if they are, these are resource led, funded by small and reducing budgets.

#### **High cost of living**

Especially accommodation, which impacts new graduates and those starting families. Better/more affordable housing for public sector workers would help, 'London Life', and locum vs permanent salary. Band 5s stated that they could not really afford to live in London and were often dependent on partners and parents or were living with their parents.

Borough representatives generally felt one of the biggest problems with recruitment and retention in the social care sector is accommodation/cost of living costs (as evidenced through exit interviews).

Band 8s suggested that it was important to create a financial incentive for occupational therapists to stay in practice in London and acknowledged that the pressures of costs in London were challenging.

### 5.10 Working environment and flexibility of working practices

For Band 6 occupational therapists there is a perception that there are limited or no opportunities to work flexible or reduced hours. One Band 6 occupational therapist reported that she had sought reduced working hours but her request was declined. There was also a perception that reduced/part-time hours were not generally available within NHS Trusts but were available within Social Care. This perception influenced employment decisions e.g. one participant working on an integrated NHS/Social Care rotation indicated that she very much enjoyed working in acute care but was glad that her employment contract was with Social Care because of the opportunities for reduced hours should she have a family in the future. Band 6s perceive reduced or minimal professional support and particularly so when this was only available at intervals and off-site.

In terms of 7-day working, the Band 6 group suggested that nurses had signed up to work a 7 day week and a shift work pattern when they began their training. The group consensus was that this had not been a consideration when most occupational therapists decided to join the profession. It was noted to be 'scary' and of great concern for most attendees. All attendees agreed that extended hours/7 day working was a good thing for occupational therapy services and service users but not for individual therapists. Two members of the group identified that this would be a strong 'push factor' as extended hours are not compatible with family life and childcare arrangements.

Several members of the group noted that they currently work at weekends for extra monies i.e. in addition to contract hours, and they valued the opportunity to do a rotation pattern of approximately 1 weekend in 4 / 6. The group discussed the challenges of evening and weekend working and in some



situations this was perceived to be more challenging as it involved lone working and could be very isolating, particularly when an individual Band 6 was the only occupational therapist on-site. Due to changes in work patterns it was noted that staff groups are frequently on different types of contract and therefore the terms and conditions of Band 6 therapists working alongside each other may be different. This was perceived to be unfair.

The Band 6 group reported that they had not been involved in any consultations or discussions that enabled them to contribute to the shaping of services, terms and conditions, apart from one participant who had taken on a union role to ensure that terms and conditions were reached with regard to 7-day working. They believed it is important that Band 6s are given opportunities of this nature not just in relation to extended hours but more generally in relation to service development and delivery. The move to 7 day working for some Band 6's would be a reason to move on.

Feedback from social care managers/senior practitioners on recruitment focused towards the impact of salaries and the lack of rotations. Some boroughs offer a recruitment retention between £1500 - £3000 pa, which does help. Lack of rotations - would like to offer a mixed rotation health and social care but due to different budgets this is not possible; salaries in some boroughs are lower than equivalent NHS jobs; there is the lack of parity with social work as the assessed and supported year in employment (AYSE) is offered to graduate social workers (i.e. the graduate goes up 2 spinal points and there is no equivalent for occupational therapists). This needs to be addressed as a priority.

Social care managers/ senior practitioners perceive that they are increasingly working within significant budgetary constraints, which creates pressure. There is pressure of workload due to increasing complexity, a feeling that the value of occupational therapy is not always recognised by senior management and the perception that during periods of organisational change, occupational therapy staff are not always listened to. There is also the suggestion that some areas of work could be carried out by occupational therapists but they remain the domain of social work, e.g. Safeguarding.

Some boroughs felt that lack of flexible working practices impacted on retention. Senior managers want staff in during the core hours of 9-5 and there is a perceived mistrust if working from home. In comparison some boroughs offer working from home and compressed hours as a more flexible approach.

In terms of organisational structures many occupational therapists are working in isolation in devolved teams but different organisational structures exist across boroughs. Feedback from occupational therapists suggests they are feeling isolated and are often managed by social workers, which may be a contributory factor to leaving. Strategies to try to resolve feelings of isolation include holding 'in days' for occupational therapy. The boroughs' group report there is a lack of senior occupational therapists capacity to take students but recognised that occupational therapy assistants (OTAs) who do the part time occupational therapy course, which is paid for by employer, remain loyal and stay working for the borough. This is a good route for employers.

### 5.11 Perceived problems with recruiting to and retaining OTs in MH and paediatrics

One of the project aims is to explore whether there is specific difficulty recruiting Band 7s in MH and paediatrics especially now as occupational therapists from non-EU countries (e.g. S. Africa, Australia) need a work permit.

The paediatric group (representing one service who sent in written comments) report difficulty in recruiting to social services positions in paediatrics, recognising that it is very difficult for Band 5s to get any paediatric experience and that there are limited student placements, therefore Band 5s are not confident to apply for Band 6 roles.

In terms of what might be influencing individual occupational therapists employment decisions in the paediatric occupational therapy workforce, it is reported that there are lots of temporary job adverts at

the moment. Even if they do get extended, this affects job security/stability and effects things such as mortgages/family plans.

A lot of occupational therapy posts in schools are effectively lone working, and some of these are at Band 5. There are risks associated with this for example, lack of supervision and not having occupational therapists within the team to work with. There is a perception that there are limited opportunities to move within areas (Paediatrics, MH, physical) which can lead to feeling that once you are in a job you are unable to move.

### **5.12 Conclusions and next steps**

As a bridge to the second phase of the Occupational Therapy Project, the Listening Event has uncovered some of the challenges faced by each band, which may be impacting the retention and attrition of the occupational therapy workforce in London.

Some of the areas identified by the participants resonate with the literature. For example, lack of support and supervision (Bands 5 and 6) and lifestyle, income, desire for different types of work and workload pressures. Working in London may serve as an extrinsic 'pull' factor as it is perceived to offer new and interesting opportunities but this does not always turn out to be the case for Band 5 and 6 occupational therapists. There is evidence of 'push' factors for Bands 5, 6 and 7 related to a perceived lack of supervision systems, training and development opportunities, line management, career advancement, the nature of the work and flexible working.

However, locum use and transition beyond the new graduate level and the work environment appear to have the most impact on retention and attrition for the participants who attended the Listening Event. This has not been shown before in the occupational therapy and wider literature and is worthy of further exploration in Phase Two of the project.

#### **5.12.1 Impact of locum use - Key points:**

- Permanent Band 5 and 6 clinicians were suffering because of high locum usage and turnover; investing energy in educating locums was misplaced and more should be done for permanent staff (locums from other countries will eventually go home);
- For Band 6 clinicians the locum situation could be perceived as instrumental in taking the decision to leave a job;
- It is tempting to also choose to locum;
- Loss of a supportive hierarchical team structure for modelling professional behaviours and resulting in gaps in practical skills;
- Educational investment in locum staff is lost to the service and they do not normally contribute to service development;
- Locum use has become normalized as a professional progression route.

#### **5.12.2 Preliminary suggestions to address the impact of locum use:**

- Better support for Band 5's;
- Reduce usage of locums or treat them like staff so that they become staff (increase accountability);
- Invest more in the permanent staff;
- More training and support is needed for permanent staff so it looks more attractive to remain rather than to locum;
- Promotion only when someone is ready;
- Good leadership is essential.

#### **5.12.3 Preliminary suggestions to address retention:**

- Need to promote networks in London

- Need to ensure retention strategies are fit for purpose
- Need to ensure that all grades of staff feel valued and included in service developments
- A need to ensure via CPD that staff involved in interviewing and recruitment have access to best practice
- Protect CPD time
- Need to ensure the 'right mix' of student placements to give confidence to newly qualified OTs, including social care placements
- Consider whether COT Regional Groups can be part of the solution in supporting the networking and learning around interview and recruitment issues

### 5.12.4 The next steps of the project will be to;

- Circulate and disseminate the outcomes of the Listening Event to all stakeholders;
- Share outcomes of the Listening Event at the South London AHP Forum;
- Write a short report for publication in OT News;
- Re-consider ways to progress to Phase Two of the Occupational Therapy Workforce Project, which would involve securing an amendment to the existing ethics approval and drawing on the outcomes of the Listening Event to shape direction and methodology;
- Subject to funding, explore the feasibility of offering an Occupational Therapy Capital programme in parallel to that in nursing (which is addressing the same issues);
- Subject to funding, explore feasibility of developing and investing in a leadership course for Bands 5-8;
- Explore the perceived lack of parity between occupational therapists and social workers who have an assessed and supported year in employment (AYSE). This is offered to graduate social workers (i.e. the graduate goes up 2 spinal points) but there is no equivalent for occupational therapists. It is suggested that this needs to be addressed as a priority;
- Deliver a high-level London Summit to discuss workforce issues to promote further discussion on the next steps and future research.



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