Primary Care Occupational Therapy FAQs

What resources do RCOT provide about primary care OT?

The RCOT Primary Care webpages are packed full of resources and include:

- Webinars of OTs, GPs and students sharing their journey and lessons learnt.
- Info about what OTs offer and who OTs see.
- Real life impact from OTs including cost savings and improved health.
- Our primary care key messages and ambitions.
- How to get pilots started in GP surgeries and how to grow these.
- Networks for primary care OTs.
- Resources like films, articles and research resources
- OT Action examples – 25 real life examples covering older adults, mental health, health and work, people with learning disabilities, high intensity users, children, chronic pain and taking OT learners on placement in primary care.
- The RCOT Workforce strategy and country plans also contain primary care as a key priority for the future.

I work as an OT in Northern Ireland, Wales or Scotland –can I work in a GP surgery?

- Northern Ireland: Occupational therapists are currently working in GP practices as mental health practitioners or managers of mental health primary care services. It's hoped that pilots will be developed to trial OT specific posts in primary care in the future. Please see the action example from NI on our primary care webpages: Developing primary care mental health services in Northern Ireland.
- Wales: Occupational therapists are currently working in a broad spectrum of posts in GP surgeries in Wales, retained on their secondary care NHS contracts. Please see the action examples from Wales on our primary care webpages which include diversifying OT delivery models; realigning secondary care OT services to primary care; being key contacts for people with dementia and meeting mental health needs in primary care. We have resources about primary care OT in Wales and contact details for relevant networks on our website.
- Scotland: Occupational therapists are currently working in a broad spectrum of posts in GP surgeries in Scotland, retained on their secondary care NHS contracts. Please see the action examples from Scotland on our primary care webpages which include creating referral pathways; impact of OT primary care services; supporting early frailty, mental health wellbeing services and pain management. We have resources about primary care OT in Scotland and contact details for relevant networks on our website.

I would like to work in a GP surgery –how do I do this?

- First find out about your local services. In england most OTs are currently employed direct in primary care but in Scotland and Wales, OTs have remained employed with their NHS employer. If you already have OTs or other AHPs in primary care locally, contact them and ask about work opportunities or advice about how they started.
- If you work in secondary care, it might be worth asking OT leads if they have ever considered a primary care pilot, outreaching into primary care to provide early intervention and upstream work. Other AHPs like paramedics have made good use of rotational models for example. Read this innovation story about realigning community OT services to primary care.
- It's useful to understand your local population to help identify groups needing OT and then tailoring your offer. For example, if your locality has high numbers of older people, you could offer cognitive screening and frailty reviews. If you have high numbers of working age adults with long-term conditions, you could offer work and health support. Using local data sources like Joint Strategic Needs Assessments can help.
- England only -GP practices are independent contractors which means they have freedom to employ the staff they wish, if it fits their business aims. If there are no OTs or AHPs already in your local surgeries, it might be worth contacting the local practice managers or GPs to discuss what an OT offer would look like. They can use different employment models from direct employment as salaried members of staff, to the use of contracts with small business, to sessional work from independent clinicians. All these may be possible.

What should I think about before working in a GP surgery?

- Style of working – Many OTs in primary care work without a team of OTs around them, sometimes in MDTs with new compilations of staff and disciplines. This has pros and cons and is worth considering against your working style and preferences.
- England -Pay, terms and conditions- If you are being employed direct by the GP practice, primary care is not covered by agenda for change pay, terms and conditions. During recruitment, ask for clear information about: Hours of work; Salary and annual pay increases; Annual leave; Maternity/ paternity pay and leave; Indemnity; Pension. If you are not satisfied with the offer, you can negotiate.
- Supervision, CPD **–** If you're employed via your secondary care NHS contract (likely from Wales and Scotland), you should be able to retain your supervision structures and CPD time –however, it be worth getting clarity of this and getting CPD time incorporated into your job plan. If you are employed direct by the GP practice (likely from England), you will have to consider where you will get your supervision and CPD from. Some GP practices will regard this as your responsibility to source and pay for. Other GP surgeries may be willing to provide some supervision and CPD from within the surgery.

- Education **–** A constant theme from primary care OTs is the degree of education that the surgery staff require about the occupational therapy offer. Many GPs will have only worked with OTs as part of their medical degree rotations in acute and inpatient care. Most surgeries have not had OTs working in them before. GP practices with a high staff turnover of GPs and reception staff will need repeated education.
- Business approach **–** Although part of the NHS, GPs work as independent contractors which means they run as small businesses. The advantage of this is that they run without waiting lists or financial deficit but to deliver this, they must focus on activity that they can claim revenue for. This business approach will impact on which services are delivered by primary care and may shape how the GPs want you to work.
- Estates **–** Many GP practices experience problems with their building which can be old with not enough space. Access to clinic room space can be a priority and may impact on how and where the OT service is delivered,

I've just started in a GP surgery –how do I network with other OTs?

We have a Primary Care Practice Network on the Communities platform which is part of your RCOT membership. It includes a discussion space where you can talk with OTs interested in primary care. It also has resources about primary care OTs including presentations from OTs about their services and projects. There are other practice networks on the platform that may also help for example for older adults, mental health, health and work. In addition, there are also networks for Wales and Scotland plus networks for OTs supporting frail older adults or people with mental health problems in primary care.

I'm new in primary care - can you give me advice about starting a new OT service?

- Start with an understanding of what professionals and services operate from primary care and what other local teams and resources are available. This will ensure what you offer is complimentary to the services. OT in primary care should focus on early intervention and prevention.
- Look at local data and ask the GPs and Practice Managers what their hot spots or gaps are. Think about the patient journey –how will patients access you? How long will you work with people for? How do they leave your service? Do you offer any follow up? Remember that primary care does not generally operate with waiting lists.
- Be prepared to provide continual education to the primary care team and others about what your service offer is. Everyone is busy and it takes time to learn about new roles and services.
- Start with a small pilot. Tell everyone it's a pilot and given them a review date. Whatever you create, this gives you the chance to pause, review and make any necessary changes. The PDSA cycle can help (Plan, Do, study, Act).

- From the very beginning think about outcomes, impact and how you can demonstrate this. Ask the GPs and practice managers if there is a type of evidence that would be useful for them. It's a good idea to think about quantitative evidence (numbers) and qualitative (words).
- Evidence could include before and after scores on outcome measures (comparison between two scores); comparing the outcomes of patients receiving OT to those who don't (comparison between two groups); comparing the number of GP contacts before and after OT; qualitative feedback from patients, carers or team members. Our pain management action examples used these approaches. Start small and change the way you collect evidence if it's not working. Find out if there's anyone at the GP surgery who can help with identifying, collecting and presenting your data.
- Tell us how it's going! We're always on the lookout for innovation stories to add to our Innovation Hub.

What outcomes measures do OTs use in primary care?

In research carried out in 2023 we asked OTs in primary care what outcomes measures they used. Those tried (listed from most to least frequently used) were:

- Multi-domain outcome measures: Canadian Occupational Performance Measure (COPM); Goal Attainment Scaling (GAS/GAS LITE); Therapy Outcomes Measure (TOMs); Australian Outcome Measure (Aus-TOMs); Worker Role Inventory (WRI); Assessment of Work Performance (AWP); EuroQol-5D (EQ-5D); Patient Reported Outcome Measurement Information System (PROMIS); Primary Care Outcomes Questionnaire (P-COQ); Functional Autonomy Measurment System (SMAF); Adult Social Care Outcomes Toolkit (ASCOT).
- Frailty outcome measures: Clinical Frailty Scale; Electronic Frailty Index (eFI); Gait (Walking) Speed Test; Edmonton Frailty Scale; PRISMA 7 Questionnaire; Time Up and Go (TUG) Test; Barthel Index (BI); Bristol Activities of Daily Living Scale; Assessment of Motor and Process Skills (AMPS); Allen Cognitive Level Screen (ACLS).
- Environmental outcome measures: Work Enviromental Impact Scale (WEIS); Residential Environment Impact Scale (REIS).
- Psychological outcome measures: Generalised Anxiety Disorder Assessment (GAD-7), Patient Health Questionnaire (PHQ-9); Hospital Anxiety and Depression Scale (HADS), Warwick Edinburgh Mental Wellbeing Scale (WMWEBS), Recovery Star; Beck Depression Inventory (BDI), General Self Efficacy Scale (GSE).

Finally, the RCOT community's platform has many practice networks who may be able to help with area specific outcomes measures.

Can OT learners go on placement in primary care?

The RCOT Occupational Therapy Workforce Strategy 2024-2025 highlights the need for OT services to focus on health promotion and prevention. This involves working with people in their homes and communities, developing the primary care workforce, and increasing primary care placements for OT students or learners.

Placements provide valuable learning experiences and help shape learners (students and apprentices) into skilled and adaptable clinicians. Learners are the future workforce and need investment. There is a clear link between those who complete placements successfully and those who secure graduate roles in the same field. For a copy of our resource about how you can support OT learners in primary care, including examples from practice, email genevieve.smyth@rcot.co.uk

Can I run groups in primary care?

Yes, although not widely used in primary care, its popularity is growing for patients who consent to it and would benefit from group consultation, intervention and peer support. It can also be more cost effective to run. We have an example of a primary care mental health group therapy program on our website, from first contact mental health OTs, and another example of OTs using Tai Chi as part of group falls prevention in primary care.

How do OTs use social prescribing and work with social prescribers in primary care?

Social prescribing enables people to participate in social activities. Enabling social participation is also at the heart of the occupational therapy profession. As such, this makes occupational therapists the obvious partner to develop, build and support social prescribing initiatives.

Occupational therapists are therefore, ideally placed to advise, lead and supervise the development of social prescribing services, especially in areas where take-up has historically been low. There should be a named lead for social prescribing in every locality, which is a role ideally suited to the core skills and competencies of occupational therapists.

Occupational therapists are not social prescribers, but their skills and expertise can enhance social prescribing services. Social prescribing should not be a replacement for expert occupational therapy intervention. Social prescribing may be viewed as the universal approach for assisting people to participate in social activities; whereas occupational therapists work with those whose needs are more complex and require a more tailored approach for them to be able to actively engage and participate in social activities.

My GP surgery is refusing to give me a pay rise in line with agenda for change –what should I do? (England)

Regular changes to the GP contract will give an indication of expected pay uplift for OTs employed under the Additional Roles Reimbursement Scheme (ARRS) in England. NHSE hopes this is honoured and passed on. But, as independent contractors, GPs are not obliged to and sometimes this is not passed on. Unison has the following advice:

Please email genevieve.smyth@rcot.co.uk with evidence of what is happening -what you have discussed with your employer, what their reason for saying no is and what, if any, negotiation you have tried. This can be shared anonymously with Unison, so they can build evidence about this problem and its scale.

Linked to the negotiation point, many of us haven't been trained to negotiate about pay and it isn't part of our mindset. But to move forward and build our case, it would be useful to know what you've tried. Although this article is from the USA and linked to recruitment negotiation, it provides some useful pointers.

Do I need to be a first contact practitioner to work in GP surgeries?

Scotland and Wales have developed OT services in primary care that include a range of different levels of OT practice from novice to consultant level. In england, if the GP surgery is using the Additional Roles Reimbursement Scheme (ARRS), it comes with the stipulation that the OT operates at an advanced level of practice (please see page 102 of the 2024/5 contract).

It is between the OT and their employer to decide how this level of practice is demonstrated. Some OTs have completed First Contact Practitioner training courses and others have trained to become advanced clinical practitioners. Outside of the ARRS funding, there is more freedom for GP surgeries to employ or host a range of different levels of OT clinician including OT learners.

I'm leaving primary care to move back into secondary care NHS services – does my time qualify as recognisable service? (England)

Additional Roles Reimbursement Scheme (ARRS) funded OT roles in primary care should be recognised as working in an NHS organization, which is important for continuous service benefits like annual leave.

Working in primary care should be acknowledged as NHS service, making you eligible for continuous service benefits, including annual leave allocation, when moving to a new NHS post.

What are the pros and cons of OTs being in the GP contract versus remaining with an NHS employer? (England)

Introduction; Although GP surgeries are part of the NHS, at its inception, GPs wanted to retain their prior, independent contractor model of operation. This has meant that since 1948, all GPs in the UK work to a contract which is regularly negotiated between the BMA's GP Commitee and each respective country government.

This process of negotiation of the GP contract covers the activity each government would like the GPs to deliver; the payment for this activity; their pay, terms and conditions and any additional monies that are available as incentives, for optional additional activity. Currently about two thirds of GP funding is in the core contract and a third is from incentives. The GP contract is outside and separate from the standard NHS contract, agenda for change pay, terms and conditions.
This contracting process usually goes through several rounds of negotiation including going to BMA member votes. Once agreed, each GP surgery (or GP partnership, which can include several surgeries) signs the contract from April.

If GP practices fulfil the contract (evidenced through coded activity in the ECR) they receive NHS money from each government. So, the content of the contract is the backbone to delivery of primary care in the UK.

The term "GP Partners" means GPs who form the partners in their business. The term "salaried GPs", means GPs who don't own or run the business, but are employed by the partners to deliver the service. The BMA provide more info about the different country GP contracts here: Contracts

Additional professionals in the GP contract: Although the policy of all four nations has been to expand the primary care team, the governments have taken different approaches to this. In summary, while the England GP contract includes different roles like occupational therapy, the other nations contracts have only included MSK and mental health practitioners.
This means that many occupational therapists working in primary care in England are directly employed by the GP practices. Those in Northern Ireland, Scotland and Wales have retained their standard NHS contracts with their original NHS employer, as part of the policy steer of each respective government. These different employment models are an ongoing debate across the UK.

Pros and cons to being part of the GP contract (mainly England):

- Outside of agenda for change agreements which could lead to worse pay, terms and conditions, disparities between different GP practices and between primary, secondary and community care OT.
- Relies on the negotiation skills of individual OTs to get the best outcome.
- Opportunity to get higher pay than standard NHS rates.
- GP Partners and Practice Managers as employers, may have more control and influence over the day-to-day activity of the OTs.

- Being in the GP contract may enhance feelings of integration for the OTs in the practices.
- Supervision, CPD and general support must be found from within the GP practices.
- Opportunity for independent OTs to offer services to GP surgeries.
- Employment with a small business may allow OTs to innovate more freely.

Pros and cons to remaining on the standard NHS contract via a local NHS employer:

- Retention of standard NHS pay, terms and conditions in alignment with nationally agreed agenda for change.
- Retention of supervision, CPD and support available from larger NHS employers with established OT structures.
- Ability to try pilots and tests of change without risk to pay, terms and conditions.
- Relies on agreement between the employer (usually NHS secondary or community care) and primary care. The employers' needs could take preference.
- Easier for the OTs to move into and out of primary care, as their contracts haven't changed.
- Easier to develop a career pathway with a range of different grades of OT. Also, may also be easier to develop rotational models in the future.

More information: The Royal College of Paramedics provide info about the GP contract and what should be considered when moving into primary care in England under Contracts:

"Primary care providers (also called General Practices), contracted by NHS commissioners for generalist medical services, are typically small to medium-sized businesses. While some are operated by individual GPs, most in England function as GP partnerships involving two or more GPs, potentially with additional staff. These partnerships jointly manage business aspects, pool resources, and share ownership of the practice.

GP partners, as independent employers, set their own pay and contract conditions, leading to variations in salary, leave, benefits, and contributions compared to the rest of the NHS. "

They advise that the following are essential elements for discussion with employers prior to working in primary care in England: Hours of work; Salary and annual pay increases; Annual leave; Maternity/ paternity pay and leave; Indemnity; Pension.