ROCKET SCIENCE

# An evaluation of occupational therapy in primary care in the UK.

## Final report for Royal College of Occupational Therapists by Rocket Science

April 2023

# Contents

# Acknowledgements

We are extremely grateful to the primary care services, and particularly the occupational therapists and other staff working in them, who have supported the research and given their time despite the pressures and constraints that the services operate under. We are also grateful for the patients who agreed to be interviewed, gave their time and shared their experiences of received occupational therapy.

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# Executive Summary

Primary care services provide the first point of contact in the healthcare system and include general practice, community pharmacy, dental and optometry services. General practitioners usually work from a general practice or GP surgery and treat a range of common medical conditions and refer patients into secondary care for urgent and specialist treatment.

All four of the UK country governments have set visions for a multidisciplinary primary care workforce now and in the future. Borne from the increasing complexity of patient care needs, a rapid growth in the population of older adults, and the resource challenges the Covid-19 pandemic has brought about each of the four nation's strategies set out objectives to increase capacity through improved partnership and multidisciplinary working. Despite these strategies and that model for the provision of occupational therapy from primary care having been in practice over the past five years, the number of occupational therapists in the workforce remains relatively low. With estimates of a total occupational therapy workforce in England of approximately 200 occupational therapists work in primary care in England, in comparison to 2,577 social prescribing link workers, 1,256 physiotherapists, and 859 health and wellbeing coaches (NHS Digital, 2023). Despite this occupational therapists conduct a number of roles and provide primary care in a number of ways including undertaking home assessments with patients and providing holistic, patient-centred, and place-based care.

Rocket Science was commissioned by the Royal College of Occupational Therapists (RCOT) to evaluate the scale and impact of occupation therapy for patients aged 65 years and over in three primary care sites in England, Scotland and Wales between October 2022 and February 2023. The evaluation, funded by Health Education England, sought to answer five key research questions:

1. What is the volume of occupational therapy being delivered within the evaluation sites?
2. What have the impacts been for patients aged 65 and over receiving occupational therapy care through their general practice?
3. What have the impacts been on general practices which provide occupational therapy care?
4. What are the experiences of occupational therapists working in general practice?
5. What are the workforce challenges to delivering occupational therapy care from primary care?

The evaluation took a mixed methodological approach combining semi-structured interviews with patients, occupational therapists and other staff in the three sites. Occupational therapists in each of the sites also administered the EQ-5D-5L at the points of assessments and discharge to 77 patients over the research period. Appointment data was also obtained from the three sites. In addition, an electronic survey was distributed to occupational therapists working in other primary care sites.

The evaluation has demonstrated that there is evidence from patients, other primary care staff and the data that occupational therapy creates capacity, enables quicker access, to appropriate care and alleviates pressure within the primary care. For example, all the patients in our study reported that they would have accessed their GP if the occupational therapy service had not been available.

Whilst there is substantial variance in the appointment data this study indicates that occupational therapists on average maintain a caseload of 30 primary care patients providing between 26-50 sessions of 30-60 minutes each per month. On average 16 patients per month were discharged from occupational therapy care, 25% of whom received just one to three appointments. For this reason, we conclude that occupational therapy can play a role in primary care transformation and NHS Covid recovery plans.

There were high levels of satisfaction from all patients receiving occupational therapy care through their general practice. Patients valued the place-based approach to care from their occupational therapist and reported the method of contact was reassuring to them. We acknowledge that occupational therapists have more time and capacity than GP's, however this is a potential asset in increasing overall patient satisfaction with primary care, which is currently at very low levels, mostly due to issues of access (Wise, 2022).

Similarly, all staff who participated in the study reported valuing the skill-mix the occupational therapist role brought to the team. Allied health professionals (AHPs) found it easy to refer to the occupational therapist and reported patient waiting times were reduced because of having them on the team. Many also linked the presence of the occupational therapist with increased job satisfaction through being able to deliver better integrated and holistic care to patients. There were also early signs of culture change and an increase in the skill mix of the multi-disciplinary teams because of having the occupational therapist role in the primary care team.

Through the study several workforce challenges and barriers to the delivery of occupational therapist in primary care were also identified. These included the recruitment of occupational therapists,

particularly from secondary care, the understanding and preparation of primary care services of occupational therapy and evidencing of the impact of occupational therapist. From these a series of recommendations are made including:

- The standardisation of metrics to record patient progress and the impact of occupational therapy and the introduction of validated tools with which to record these
- Supporting with occupational workforce to implement standardised data collection, understand the importance of this and how the data will be used
- Ensure support for addressing structural and cultural issues in implementing occupational therapy within primary care. This includes educated the wider health workforce in relation to the roles and skills of occupational therapists and developing tools and processes, such as pathway flows, for implementation of occupational therapy in primary care
- There is a need to address barriers to recruitment of occupational therapists from secondary to primary care, particularly within England where there is not a parity of esteem or equitable terms and conditions for those working in primary services.

# 1. Introduction

Occupational therapy and occupational therapists work with patients in a range of ways, to improve their everyday life outcomes, maintain their functional ability, or to slow decline in independence, depending on the individual patient and their needs.

Delivering occupational therapy as part of primary care may help to improve access to timely interventions. Where occupational therapists work as part of general practice, they can benefit from and offer benefits to GPs and other allied health professions (AHP) to offer person centred care to patients. However, there is little research available on the specific impacts of occupational therapy delivered in primary care to the over 65 age group of patients.

A literature search was conducted using the IDOX Knowledge Exchange database, as well as Google Scholar. Initial search terms were the impact of occupational therapy, in primary care or in secondary care, and specifically the impact on patients aged over 65. In anticipation of limited results, a search was also done for literature on the impact of access to physiotherapy in primary care, for this age group, as a comparator allied health profession. Additional search terms of reablement and rehabilitation were included to broaden the results available. The search initially looked for literature from the past five years, though this was expanded to increase the results.

Targeted searches were then conducted to answer specific emerging questions around the outcome measures used in occupational therapy. Further targeted searches were conducted on the background and context to the changes in NHS structures and commissioning in England, due to the relevant context for framing workplaces challenges for this geographic context.

This section of the report draws together literature, guidance and policy on the impact of occupational therapy in primary care on older patients. In particular, focusing on the rationale and impact of delivering occupational therapy services, to patients aged 65+, as well as drawing on experiences of other allied health professions (AHP) on the successes and barriers of delivering effective services for patients in this setting. This underpins the rationale for delivering occupational therapy in a primary care setting, particularly via GP practices, and sets the context for this evaluation.

## 1.1 Current challenges and changes in primary care

Primary care is essential in all countries to provide a system for healthcare for the whole population, and for the promotion of public health (Hanson, et al., 2022; World Health Organisation, 2021). However, the provision of its services, its design, and priorities are shaped by finance and funding arrangements (Hanson, et al., 2022), and there is a need for provision to become more multidisciplinary, and its funding to become increasingly diverse. In addition, following the challenges faced by primary care in the COVID-19 response, multidisciplinary working was seen to be an essential success factor, and the agility and innovation that characterised this time is recommended as ongoing factors for the delivery of an effective primary care system (Kumpunen, et al., 2022). This is recognised and evident in the primary care strategies in all four nations of the United Kingdom (NHS England and NHS Improvement, 2022; NHS Wales, 2022; Scottish Government, 2021; Department of Health, 2016)

Primary care is frequently cited as facing increased challenges (Lawson, 2023; Roderick & Pollock, 2022; Kumpunen, et al., 2022). In the English context this is often linked to ongoing changes to commissioning practices and structures (Roderick & Pollock, 2022), as well as globally the issue of changes to ways of working and workloads during the COVID-19 pandemic (Kumpunen, et al., 2022).

In England in particular, there are challenges around budgets, commissioning, and service provision, particularly on staffing levels with concerns that the 2022 Health and Care Act will further devalue the NHS as a whole (Roderick & Pollock, 2022). The Act includes the move to formalised Integrated Care Systems (ICS) formed of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs). This is a major structural change in how the NHS is organised in England, with an increasing focus on collaboration and place-based delivery (The King's Fund, 2022). These issues may be addressed by taking advantage of:

- the opportunities of increased multidisciplinary working and
- the independence being created in local service planning and provision, particularly in England, to design and shape primary care services in ways that work efficiently for practitioners as well as providing excellence in care to patients.

The context in Wales and Scotland is not affected by the same structures of provision and is unlikely to face the same challenges. There is however a lack of literature on any current challenges or opportunities for the provision of occupational therapy in Scotland and Wales, but certainly the focus on challenges and changes across primary care following COVID-19 apply across the whole UK and

beyond (Lawson, 2023; Kumpunen, et al., 2022), as well as the global issue of an aging population and a need for healthcare systems to increase the focus on management of chronic conditions (Donnelly, et al., 2023).

One of the opportunities expected to be created through the shift towards place-based care systems is an increase in multidisciplinary working. This may provide a model for primary care networks to meet population health needs (Jackson, et al., 2022).

However, embedding occupational therapy as part of a wider integrated care offer is not without its challenges (Donnelly, et al., 2023; Donnelly, et al., 2013). Some of the factors for success suggested in the literature include relationship building across agencies, and strong multi-disciplinary teams, and building trust and respect (Jackson, et al., 2022; Donnelly, et al., 2013). This needs to be driven by strong leadership; shared standards of practice, co-location of services and shared systems (Donnelly, et al., 2013) and potentially including shared systems for professional supervision (Kelly, 2015).

## 1.2 Benefits of occupational therapy in primary care for older adults

There is limited research specifically into the impact of occupational therapy for older adults in a primary care setting. This body of literature does however illustrate some of the essential impacts on patients (Donnelly, et al., 2023). In addition, there exists some supportive literature demonstrating parallels for ways of working from other allied health professions (AHPs), as well as for specific medical conditions.

For example, occupational therapy has been found to be a cost-effective treatment for prevention, care, and treatment in relation to dementia (Knapp, et al., 2013) as well as an effective way to deliver preventative care to promote mental and physical wellbeing in older adults (Clark, et al., 2012). Earlier research also concluded that occupational therapy was important to improve quality of life, reduce incidence of falls, improve social interaction, and benefit both patients and carers, in the context of older patients (Ryburn, et al., 2009). It is also recommended through NICE guidelines that both occupational therapy and physical activity interventions can effectively promote mental wellbeing in older adults (NICE, 2008). Although these studies took place in both community settings and secondary care, they are relevant for primary care settings, particularly in relation to preventative approaches to managing chronic conditions.

Despite the limited evidence for the delivery of occupational therapy in primary care specifically, this body of evidence is growing, along with the delivery of occupational therapy in primary care (Donnelly, et al., 2023). Delivery in this setting is typically person-centred, and the literature provides the most evidence for adults and older adults, including the importance of occupational therapy for management of chronic conditions particularly in older adults. This, along with self-management, linking with other services, health promotion and fall prevention were all main focuses for delivery of occupational therapy (ibid).

This evidence also relates to literature on reablement, rehabilitation and recovery. Reablement, rehabilitation and recovery services were found to have a significant impact on the physical independence of patients living with a physical disability, and to reduce their care needs, often increasing their ability to live independently at home (Slater & Hasson, 2018; Francis, et al., 2011). This supports the evidence that there is a role for occupational therapy to support ongoing independent living for older adults and provides evidence of this in a community setting.

Outside of the UK-specific context, a review of literature also found that there is a growing body of evidence on the impacts of community-based occupational therapy, particularly on mental health and in older adults (Estrany-Munar, et al., 2021), albeit with a broader definition of community-based delivery than could be defined by primary care. This review suggested that the most beneficial outcomes were typically around fall prevention and improved daily living. This also echoes UK-specific research into the importance of occupational therapy for promoting social participation in older adults (Turcotte, et al., 2018), which found that while occupational therapy had a key role to play, the focus on social participation as a main patient outcome should have more focus across all aspects of patient healthcare.

## 1.3 Outcome measures

Additional targeted searching was conducted to understand the range and use of tools available and used to measure patient outcomes by occupational therapists and other AHPs in primary care. These search terms included outcome measurement tools, primary care, physiotherapy, reablement and validity. Specific tools were also searched for, informed by RCOT listing of commonly used outcome measurement tools. The search was not restricted to a specific timeframe in order to include initial publications following the development of these tools. A 2015 report by Public Health England concluded that there is a need for standardised health and wellbeing outcome measures across the range of AHPs in order to understand population level impacts and allow for comparable data across different interventions (Hindle, et al., 2015). This has also been identified as part of the wider need to

provide strategic and joined up services with a person-centred approach when delivering care for older people (Oliver, et al., 2014). However, while literature exists on the use of specific outcome measurement tools for specific medical conditions or issues, there was little recent evidence on the overview of the use of standardise tools for the occupational therapy profession as a whole. This suggests that a systematic review of outcome measurement tools and their uses would be beneficial.

Measuring outcomes at an individual level can be an essential tool for assessing current patient status, goal setting, and tracking progress, as well as for reporting at a wider level (Unsworth, 2001). However, research also suggests that patient outcomes should be tailored to the individual's goals, context, and circumstances, which makes it difficult to use overarching measures across all people and services (Wilde & Glendinning, 2012). Likewise, while studies have tried to gauge the most commonly used tools, they have concluded that the use of outcome measures is varied and reflects the variation in practice, context, and patient needs (Stapleton & McBrearty, 2009).
In summary, there is evidence of potential benefits of occupational therapy in primary care for older adults. Particularly on patient outcomes around independent living, quality of life, social participation and mental wellbeing. Occupational therapists are also key for reablement, rehabilitation and recovery, relationship building, and are a cost-effective intervention, although the cost-effectiveness in primary care specifically and across all patient types has not been researched.

However, the evidence base still limited and research into the key considerations and success factors for delivering and embedding occupational therapy specifically in the primary care setting is absent. Although a scoping review has brought together much of the evidence for this, it continues to be a growing research focus as occupational therapy delivered through primary care continues to grow.

Tracking patient outcomes from occupational therapy at population level is also difficult as there is a widely varying use of outcome measures in practice. Outcome measurement tools are often used primarily as a tool for patient engagement and goal setting, ahead of reporting on outcomes. There is a need to capture the wide range of patient contexts and treatment types across the whole of occupational therapy practice. This makes it difficult to find common standardised outcome measures that would be useful both for patient interventions and for data tracking at a larger scale.

This research seeks to build on the evidence base through addressing five key research questions

1. What is the volume of occupational therapy being delivered within the evaluation sites?
2. What have the impacts been for patients aged 65 and over receiving occupational therapy care through their general practice?

3. What have the impacts been on general practices which provide occupational therapy care?
4. What are the experiences of occupational therapists working in general practice?
5. What are the workforce challenges to delivering occupational therapy care from primary care?

# 2. Methods

To answer the research questions a mixed methodological approach was taken across the three fieldwork sites.

This study took a social constructionist approach to the methodology and methods were chosen to reflect that and enable the team to investigate perspectives and experiences of patients and staff. This meant that we did not seek to triangulate findings from interviews as we recognised that all perspectives were valid and individualised. However, we did test out findings with staff members in interviews to try to understand if the finding resonated with their experience or if it was relevant only to that interviewee. The team worked iteratively with the data which enabled a close working relationship between the data, the fieldwork sites and the study participants.

An evaluation framework was developed to ensure that all research questions would be addressed by the methods as well as identifying sources of relevant data. The evaluation framework was developed by Rocket Science in consultation with RCOT. The full evaluation framework is available in Appendix 1. Approved research materials, including staff and patient interview topic guides and patient information sheets were designed based on the Key Evaluation Questions and approved with RCOT can be found in the Appendix.

# 2.1 Sample

## Research sites

Five research sites[1] were originally identified and purposively sampled by the Royal College of Occupational Therapists. Selection was on the basis of providing occupational therapy to older adults, were delivering within three of the four UK nations and had, at the time, capacity to support the implementation of the research. Over the duration of the project two sites were no longer able to support the research and therefore three sites, one each in England, Wales and Scotland are included.

Each research site comprised a number of primary care services from which patients and staff were recruited for interview and differing number of occupational therapists working across them. In total 7 occupational therapists supported the research across 17 primary care practices.

## Participants

A total of 17 patient and 27 staff (including seven occupational therapists) interviews were conducted across the three participating primary care sites.
At each participating NHS site, occupational therapists working in GP surgeries were our key point of contact. Several meetings were held via MS Teams to brief them about the project, take questions and notify them of project updates. Occupational therapists were asked to identify patients aged 65 years and over whom they had treated. In line with our Ethics approval, occupational therapists took informed consent with the patients, gave them the Patient Information Sheet, and passed their phone number to Rocket Science to arrange a telephone interview. Rocket Science contacted each patient and arranged a time for an interview over the phone. At the start of each phone interview, Rocket Science staff reminded the patients that the interview would be confidential, was voluntary and they could stop it at any time. Patients were informed by their occupational therapist that they would receive a £25 gift voucher to thank them for their time in line with National Institute for Health and Care Research (NIHR) guidance.

[1] We refer to research sites as those with a R&D team, as such the sites identified comprised of an Integrated Care Board, A Primary Care Network, A Heath and Social Care Partnership and a Health Board.

Staff were recruited by the occupational therapists working in general practices. Their names and phone numbers were shared with Rocket Science by the occupational therapists once consent was received, and the research team contacted staff to arrange a mutually convenient time to conduct the interview via Teams. Job titles of staff participating in interviews include Advanced Clinical Practitioner, Lead Social Prescriber, Occupational Therapist, Physiotherapist, Practice Manager, GP, Advanced Nurse Practitioner, Paramedic and Mental Health Practitioner. The study interviewed seven occupational therapists across the three sites.

In addition, three carer interviews were completed.

## 2.2 Instruments

### EQ-5D-5L

Occupational therapists in each of the primary care practices administered the EQ-5D-5L outcome tool to collect patient data at the point of initial assessment and discharge from care during the research period. The EQ-5D tool was chosen as it is a validated and widely used (Herdman, et al., 2011) clinical outcome tool used for both clinical decision making and research in relation to patient health across five relevant domains:

- Mobility
- Self-care
- Usual activities
- Pain/discomfort
- Anxiety/depression

Through discussion with the research sites, it was identified that the EQ-5D was already administered in two of the sites and was familiar with a number of occupational therapists. The EQ-5D-5L was used on a self-assessment basis by patients although occupational therapists were able to assist in its completion where required between November 2022 to February 2023.

An Excel spreadsheet was provided to the research sites to enter data, using an anonymised code to match entry and exit scores for each patient, and using drop down lists to record the levels for each domain. These were then summarised according to their numerical score.

## Interviews

Semi-structured interviews were developed to collect data from patients and staff in relation to their perspectives and experiences of receiving and delivering occupational therapy from the patient's GP surgery. Interviews were also conducted with other members of the GP surgery team to gather data on their perspectives of working with an occupational therapist on the team and any impacts this might have had on their working lives and practice. All interviews were completed via telephone or MS Teams.

In order to further understand the impact of occupational therapists working in primary care we conducted a series of one-to-one semi-structured qualitative interviews with patients and staff from the GP surgery sites engaged in the study. Interviews sought to produce findings that would further understanding of the impact on patients and staff of the provision of occupational therapy from primary care. Interviews also collected data on any workforce barriers and enablers to providing occupational therapy from primary care.

## Survey

An electronic survey was conducted with occupational therapists working in primary care to understand their patients' needs, the impact on patients, the interventions and caseload involved, and to assess the outcomes measures that were used. The survey also enquired about workforce challenges that occupational therapists face in the primary care setting and the solutions to these. The survey was designed in close collaboration with RCOT to develop the questions and build upon a previous survey of primary care practitioners conducted by the college Royal College in May 2022. The survey was distributed online by RCOT, to the RCOT Primary care email network (with 250 occupational therapists), shared on two primary care Facebook sites, and on Twitter.

The survey ran from 1 November 2022 until 30 November 2022, with one reminder email sent to the distribution list part way through this time.

## Appointment and outcome data

To determine the volume of activity within each of the three research sites appointment data relating to the total number of appointments occupational therapists had held with older adults between January 2022 and December 2022 was collected. These data were drawn from electronic care

records and shared with us for analysis. Some practices provided data for a single occupational therapist, while others shared appointment data for the whole occupational therapy team. Appointments were included for all appointment types with patients aged 65 or over.

## 2.3 Ethics

Ethical approval was received from HRA and Health and Care Research Wales on the 3rd November 2022 (IRAS number is 318448) and subsequently research and development approval within each of the research sites. Approval for the survey of primary care occupational therapists was provided by RCOT.

The main ethical considerations of the study included:

- Protection of personal and special category data and conforming with the requirements of GDPR. Recruitment of patients was led by the primary care occupational therapists in each of the research sites. This included obtaining informed consent including permission to pass on contact details to the evaluation team. Occupational therapists were provided with brief training by the evaluation team as well as provided with participant information sheets and tools to obtain consent. Once received all personal identifiable data was held separately from interview data and in accordance with GDPR requirements. Research tools were designed to not require participants to disclose medical information and the research team were instructed not to record or subsequently delete any medical information which was spontaneously provided.
- Additional burden on primary care staff. We were aware of the pressures that exist within primary care and the additional time pressures research can pose. Both Rocket Science and the Royal College of Occupational Therapists worked closely with identified sites to ensure there was sufficient capacity to support the research. Research tools were designed to be efficient and collect all information required from stakeholders through a single contact.
- Safeguarding of participants. It was anticipated that potential participants may experience a range of possible vulnerabilities, possibly including wavering or diminished capacity to provide consent. All occupational therapists involved in the recruitment of the participants were instructed to use their clinical judgement in relation to obtaining consent. Processes between the research and primary care sites were established to ensure any concerns of safeguarding issues were appropriately escalated and shared.

# 3. Analysis

## 3.1 Survey data

Survey results were collated, and then analysed and presented using Excel. Data were not further analysed by subgroups (e.g. by nation, or job title) due to the relatively small number of respondents in the potential subgroups of interest.

The survey primarily used closed questions with a mix of single choice and multiple-choice questions. These were analysed using frequency tables, with percentages calculated based on the number of respondents per question, therefore excluding any non-responses.

Where free text numerical questions were used (e.g. number of GP surgeries that respondents work with), the range, mean, median and mode were calculated. In addition, the responses to these questions were grouped into categories with a frequency table of responses in each category. These categories were determined depending on the spread of the data.

Open questions with free text responses were used to elicit information on solutions to workplace challenges, gaps in meeting patient needs, and rating the overall experience of working with other primary care colleagues. Free text was also used at several points to collect further information when respondents answered 'other' to a closed question. Free text responses were analysed thematically, with an iterative coding process. Two team members agreed on the coding, and maintained a close relationship with the data, as themes emerged.

## 3.2 EQ-5D-5L data

While the EuroQol guidance suggests presenting the scores across the five domains as a five-digit number (e.g. 13241), some of the research sites shared collated results for patients where the EQ-5D score was added together to form a single figure (e.g. 1+3+2+4+1 = 11). Therefore, for sites that shared the data broken down by each level, we converted this into a total score in order to have comparable data across the sites. The lowest (best) score theoretically possible therefore is 5, while the highest (worst) score is 25.

Occupational therapists at each site were asked to complete an Excel spreadsheet recording EQ-5D. In total, patient data were available from all research locations. They were analysed by comparing change in the average scores (mean and mode) for the whole dataset of matched pre- and post-scores. In addition, the total number of individual patients who had seen an improvement, worsening, or no change in their score were counted.

## 3.3 Interviews

The interviewers took detailed notes as the interviews as they took place. The notes were uploaded into MAXQDA and thematically analysed by two members of the research team independently. Coding was developed through team discussion and analysis of the data. Themes generated from the data were analysed regularly during fieldwork within the team.

## 3.4 Appointment data

Appointment data was descriptively analysed within Excel. Data has been aggregated across all research sites to ensure anonymity.

# 4. Findings

There were a series of quantitative methods used to address the research questions. This included a survey with occupational therapists working in primary care, appointment data collated from the research sites, and outcome measures for patients at the research sites. The methods used are discussed above, and the results of each of these are presented in the following sections, 4.2 to 4.4.

## 4.1 Survey findings

In total there were 103 partial or complete responses, from a distribution of 250 occupational therapists working in primary care. This section of the report summarises those findings.

### Needs, interventions and volume of activity

Most survey respondents were based in England (66%), while 20% were based in Scotland, 14% in Wales and one percent in Northern Ireland (see Figure 1). Most worked as occupational therapists (71%), 17% were mental health occupational therapists and 13% had another job title, shown in

Figure 2. Of these ‘other’ job titles, they included advanced clinical practitioners, mental health practitioners and team- or clinical leads (see

Table 1).

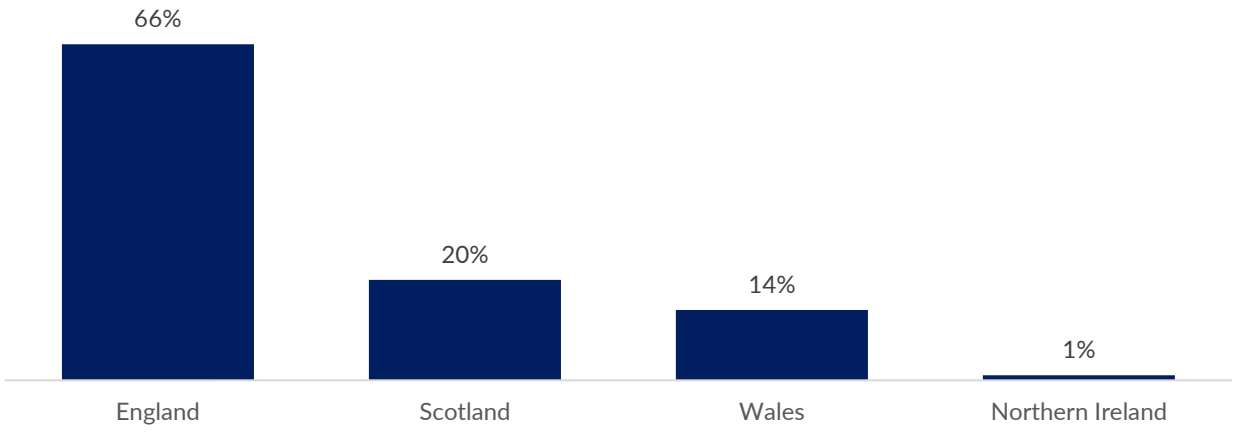


**Figure 1 Country survey respondents work in (n=102)**

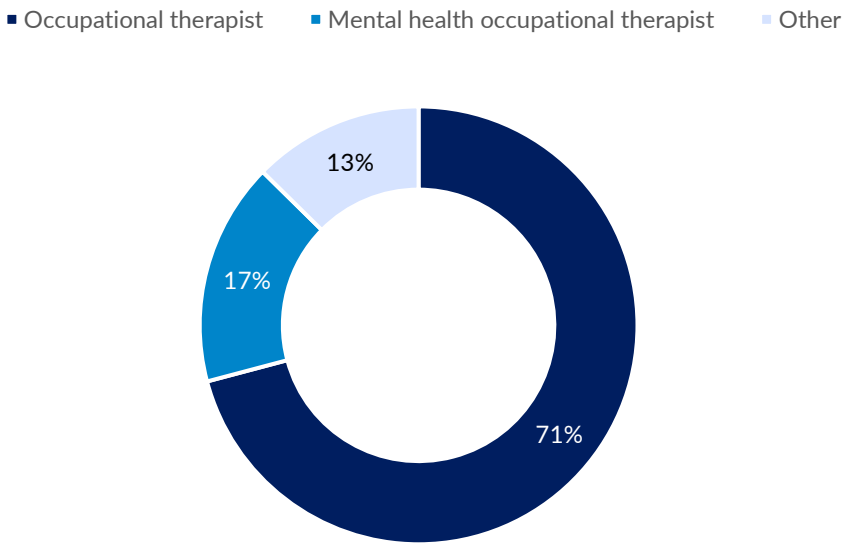


**Figure 2 Survey respondent job titles (n=103)**

Table 1 'Other' job types of survey respondents

| Job type | Count |
|---|---|
| Advanced Clinical Practitioner (Occupational Therapist) | 6 |
| Mental health practitioner | 5 |
| Clinical Lead/Team lead | 2 |

The number of GP surgeries that survey respondents worked with ranged between one and 61, with the mean being seven surgeries, but the mode being just three. These have also been grouped into categories of size, shown in Figure 3 below.

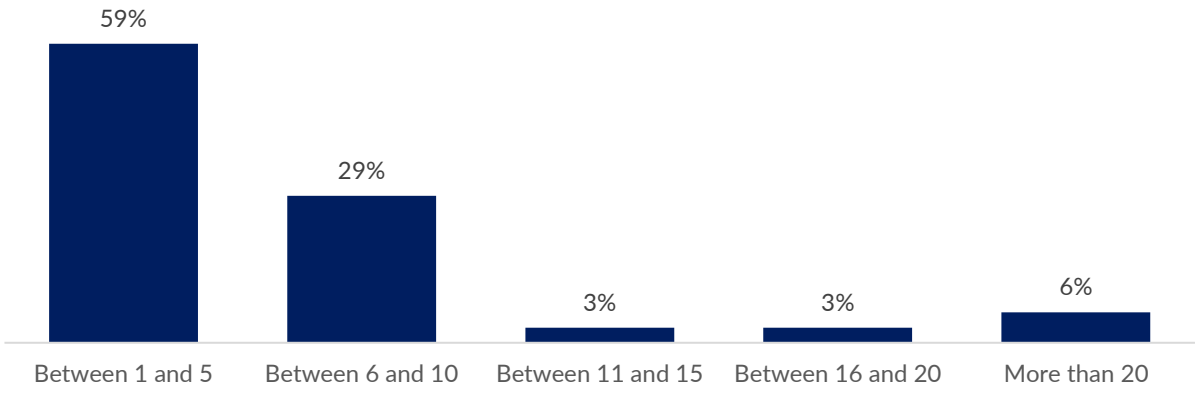


Figure 3 Number of GP surgeries respondents work with (n=100)

The most common presenting needs of patients' survey respondents see in primary care were decreased functional ability (for 71 survey respondents), frailty (66), mental health (64) and social isolation (62), shown in Figure 4. Note that survey respondents could choose more than one answer.

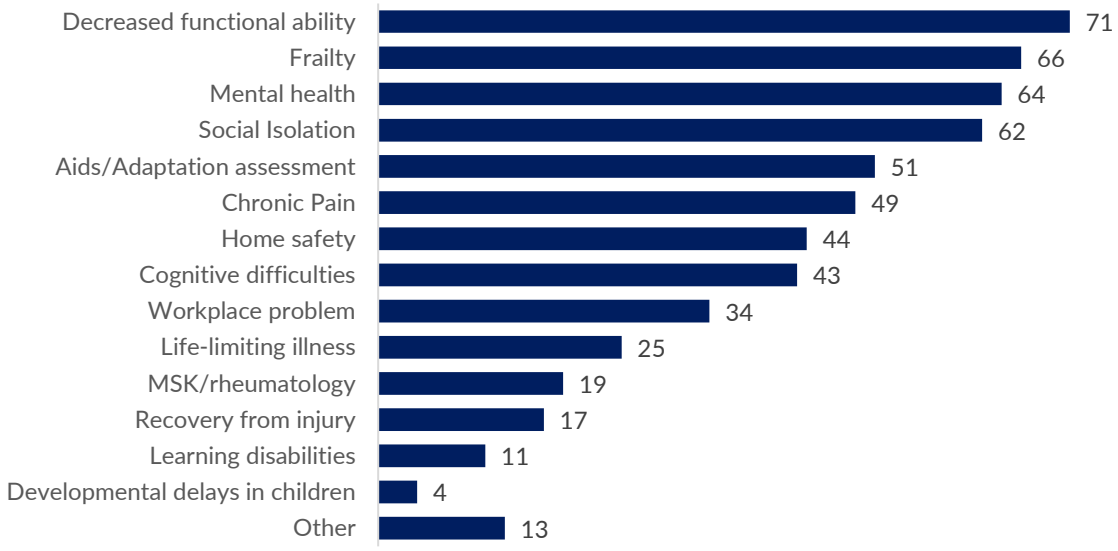


**Figure 4 Commonly presenting needs for occupational therapy patients in primary care (n=102)**

The most frequently used occupational therapy interventions and/or types of support are shown in Figure 5. These include signposting and referring to other sources of support, problem solving and goal setting, self-help, or self-management advice, and grading or adapting activities. Survey respondents could choose multiple responses.

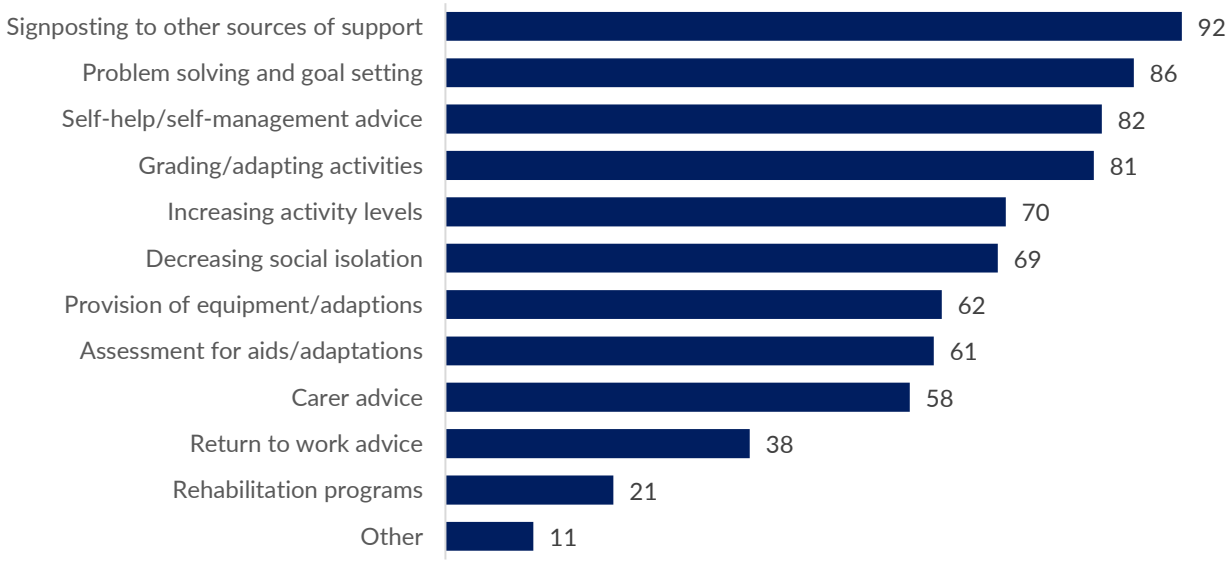


**Figure 5 Occupational therapy interventions and support used most frequently in primary care (n=102)**

Survey respondents were asked about how many new patients they typically take on in one month, on average. This ranged between three and 160, with the mean being 26 and the mode ten (see Table 2). These have been grouped into categories, shown in Figure 6, which shows that most

respondents have up to around 20 new patients a month. There were some outliers in the data, and the spread of patient numbers is shown in Figure 7 to visualise how the five respondents with 100 or more new patients per month relate to the rest of the data.

**Table 2 Average number of new patients per month**

| | |
|---|---|
| Min | 3 |
| Max | 160 |
| Mean | 26 |
| Median | 17 |
| Mode | 10 |

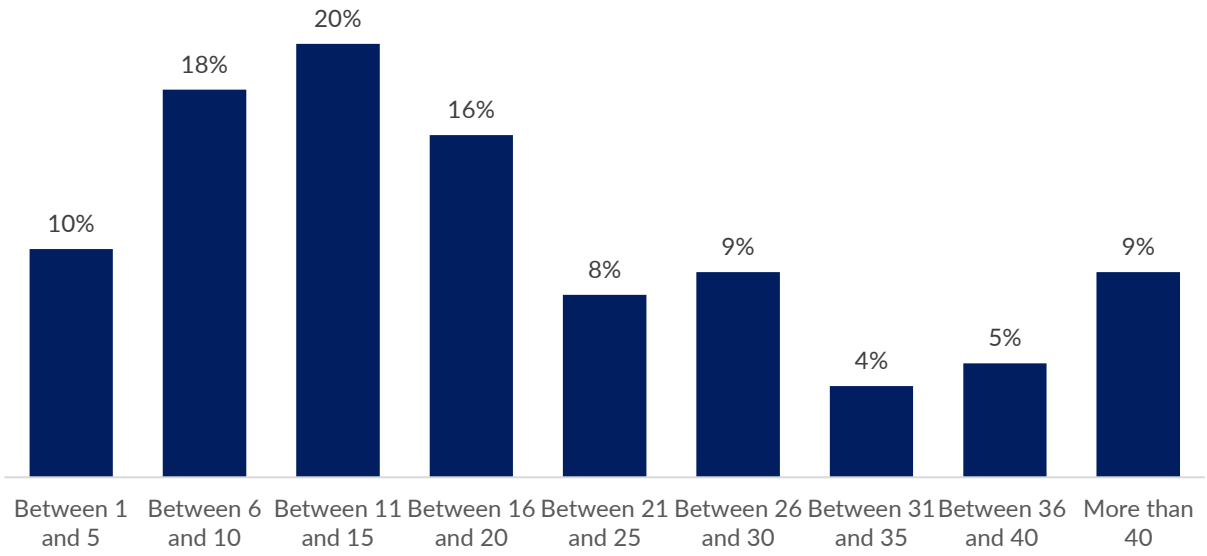


**Figure 6 Average new patients per month (n=96)**

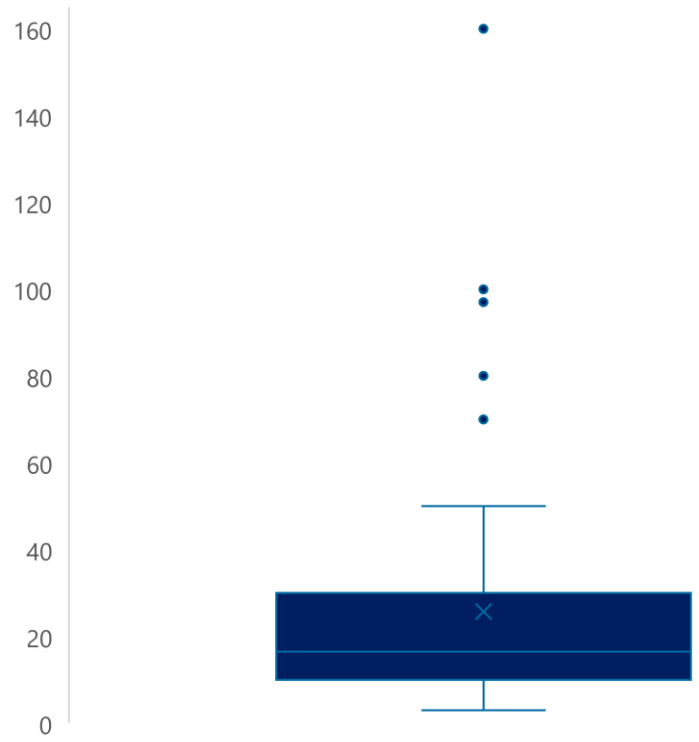


**Figure 7 Distribution of new patients per month, showing data outliers**

For those survey respondents that carry an ongoing caseload (n=83), the number of patients on the caseload per month ranged between five and 100 (shown in Figure 8 and Table 3). The mean and mode were both 30. There are a small number of respondents with high ongoing caseloads, and these outliers have been plotted in Figure 9.

**Table 3 Average caseload size per month**

| | |
|---|---|
| Min | 5 |
| Max | 100 |
| Mean | 30 |
| Median | 25 |
| Mode | 30 |

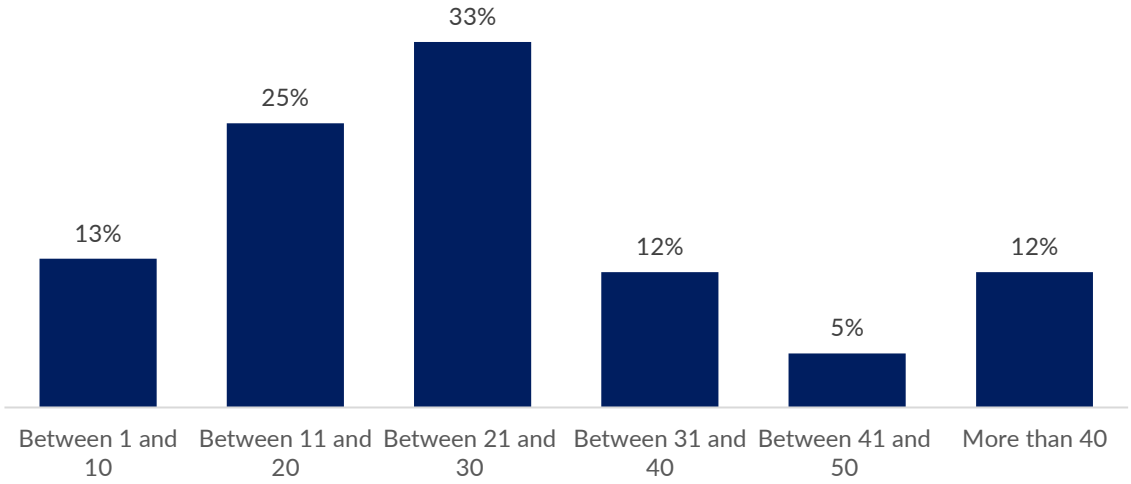


Figure 8 Average caseload carried per month (n=83)

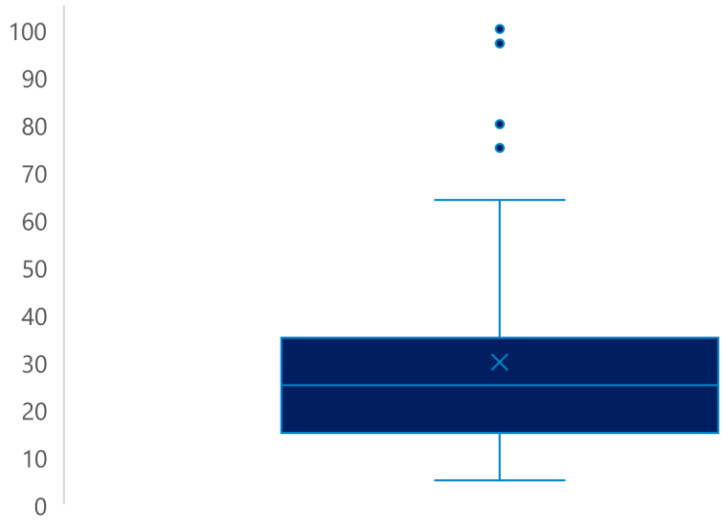


Figure 9 Ongoing caseloads per month, showing data outliers

Survey respondents were asked how many patients they discharge on average per month. This ranged from between 0 and 160 people, shown in Table 4. The mean was 16 and the mode ten. These responses were grouped into categories, shown in Figure 10.

Table 4 Average number of patients discharged per month

| | |
|---|---|
| Min | 0 |
| Max | 160 |
| Mean | 16 |
| Median | 10 |
| Mode | 10 |

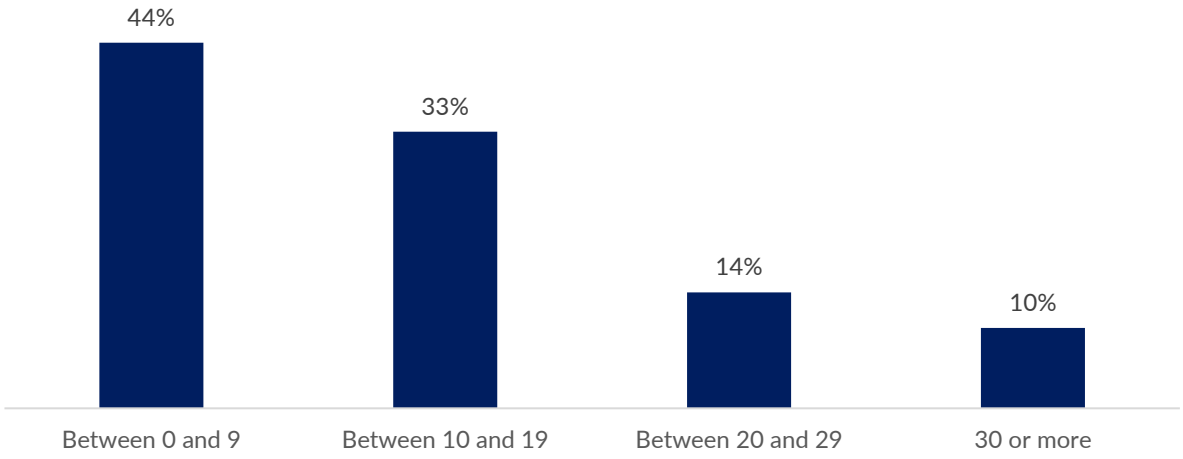


Figure 10 Average patients discharged per month (n=94)

The appointments that occupational therapists offered in primary care were usually a range of different types, shown in Figure 11. The most frequently used was phone appointments (89), followed by home visits (76) and face to face in a GP surgery (61). Again, respondents could choose multiple answers.

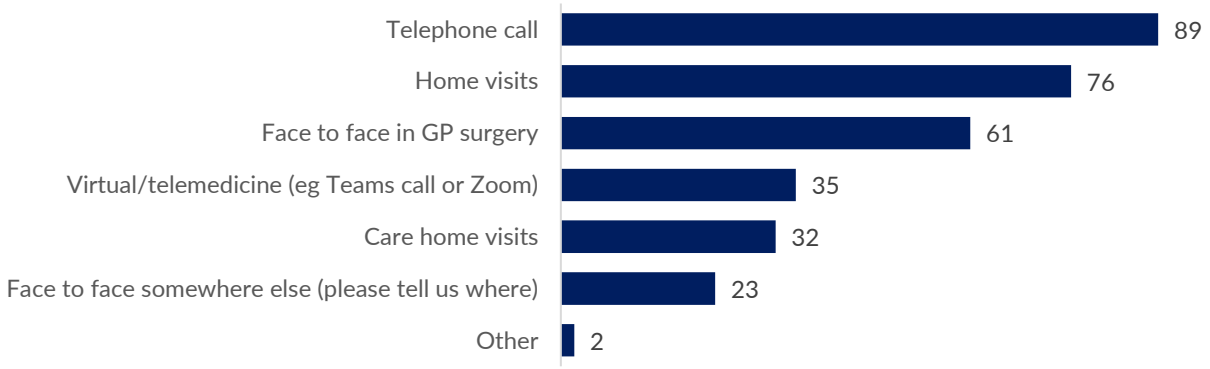


**Figure 11 Appointment types offered in primary care (n=100)**

Respondents were asked how many total patient interactions they have during a typical month, including all of the appointment types listed in Figure 11. Most respondents said this was between 26 and 50 interactions (35%), though 14% respondents had over 100 patient interactions per month, see Figure 12.

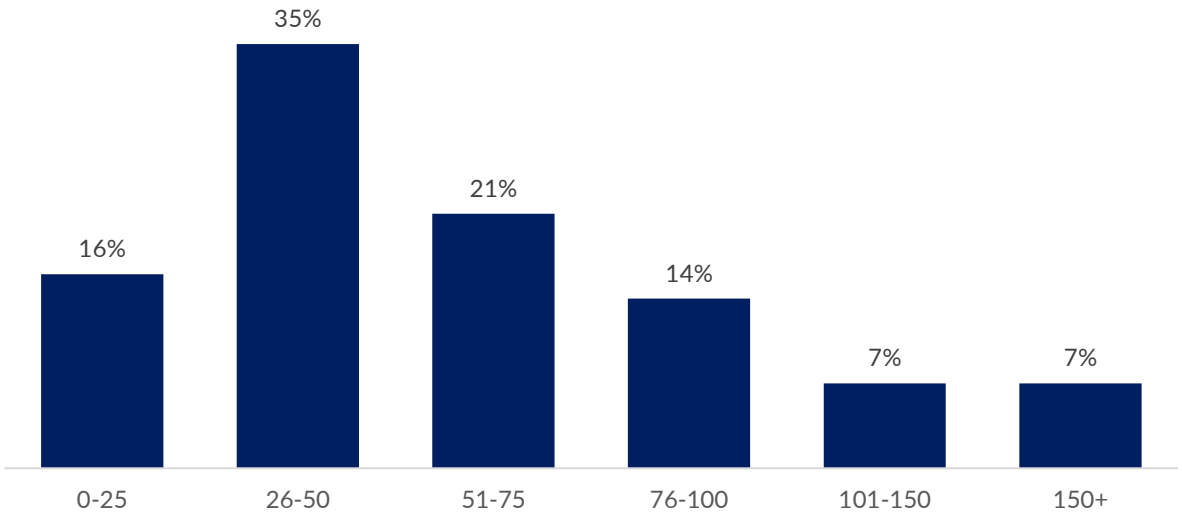


**Figure 12 Approximate total patient interactions per month (including all appointment types listed in Figure 11) (n=100)**

The average session length with a primary care patient was for most respondents between half an hour and an hour (65% respondents), or even one to two hours (30%), shown in Figure 13. Just five percent of respondents said they typically spent 15 minutes to half an hour with a patient, and none said they spent less than 15 minutes

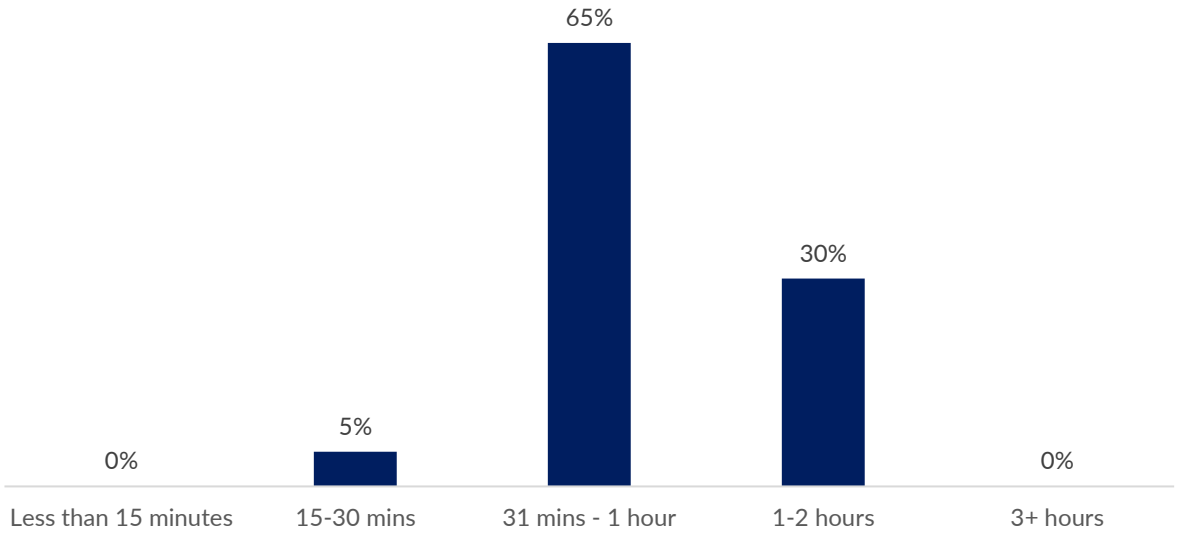


**Figure 13 Average session length with primary care patient (n=99)**

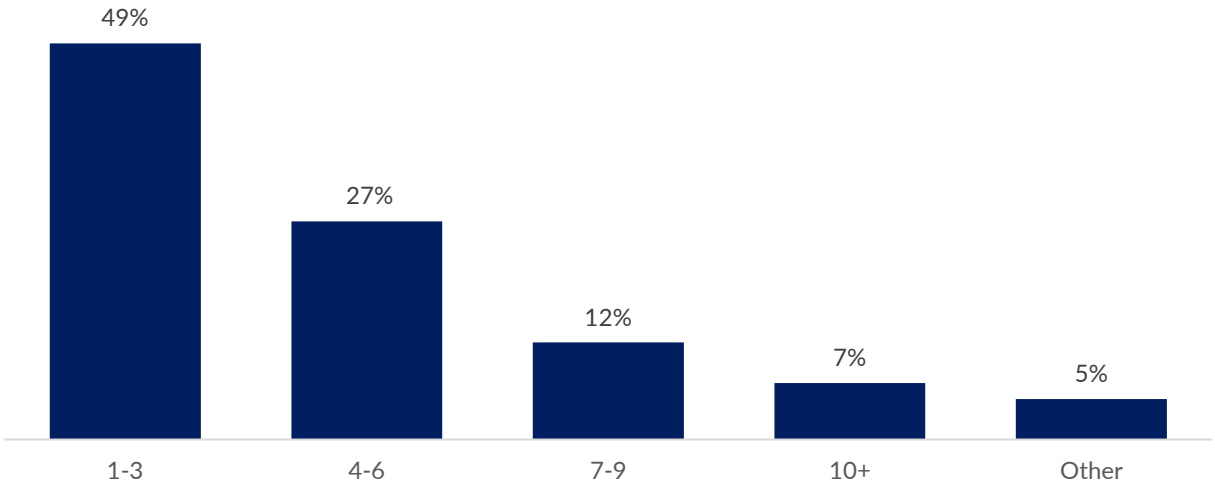


**Figure 14 Average number of appointments with a patient before discharge (n=100)**

Respondents were asked what percentage of patients they needed to see for more than two appointments, (see Figure 15). The most common response was up to a quarter of patients being seen for more than two appointments (33% of respondents reported this). In total 57% respondents reported that less than half of their patients have to be seen for more than two appointments. However, 43% of respondents said they saw more than half of their patients for more than two appointments.

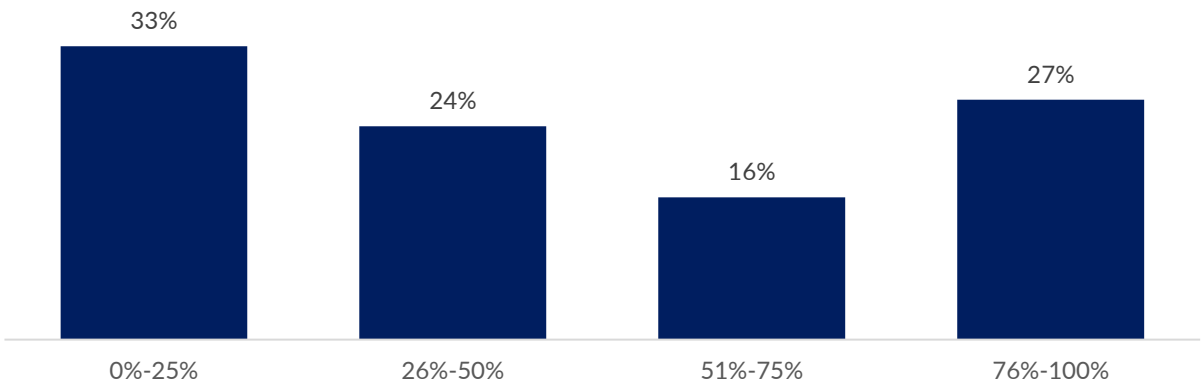


**Figure 15 Average proportion of patients who are seen for more than two appointments (n=100)**

## Outcomes and outcome measures

The occupational therapist survey asked about patient outcomes, referrals within and outside of primary care, and the tools used to measure patient progress.

Most survey respondents strongly agreed that occupational therapy interventions in primary care had a positive impact on patients and/or their carers (78%), and that they improve outcomes for primary care patients and/or their carers (75%). They also agreed (24%) or strongly agreed (64%) that occupational therapy interventions create efficiency or alleviate pressure in primary care. The response was more mixed when asked if occupational therapy interventions reduce onward referrals to social care, though most still agreed or strongly agreed with this (64% in total), while 24% said they neither agreed nor disagreed. Just 12% respondents disagreed or strongly disagreed with this statement (see Figure 16).

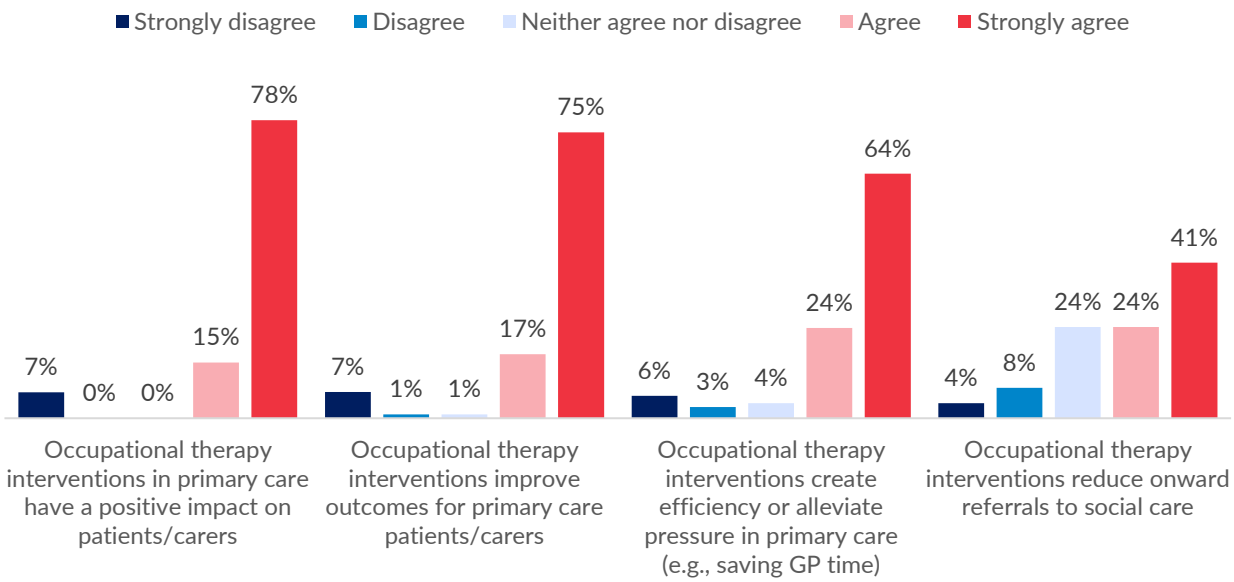


**Figure 16 Extent to which occupational therapists agree with the statements (n= 102)**

When asked how often they referred patients to other members of the primary care team, most respondents said they did this sometimes (57%), often (26%) or always (3%), shown in Figure 17. Just 14% of respondents said they rarely did this.

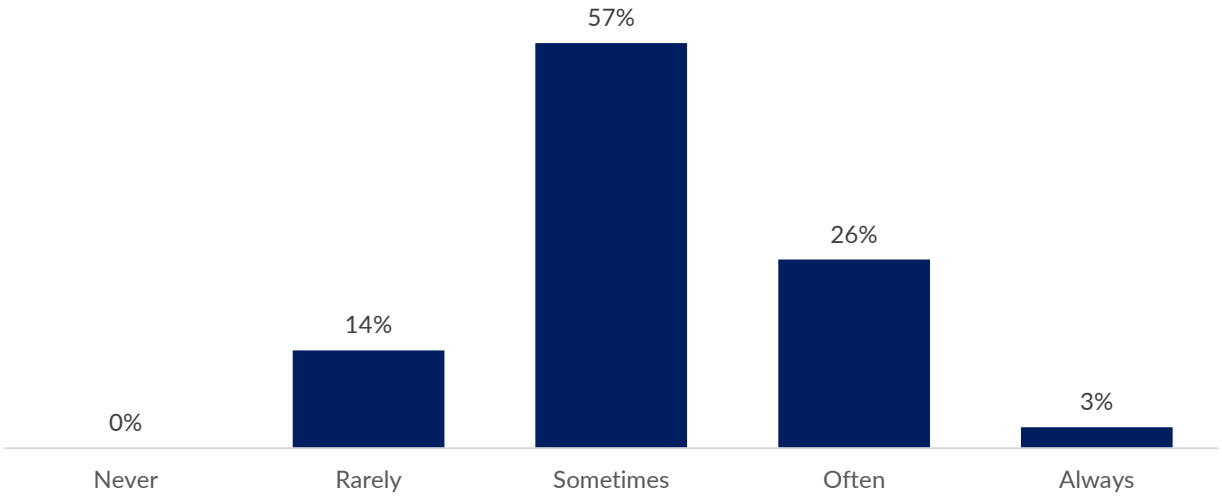


**Figure 17 How often occupational therapists refer patients to other members of the primary care team (n=102)**

As a follow up, survey respondents were asked which other health professionals in the primary care team they generally referred patients to, shown in Figure 18. Note that respondents could choose multiple options. GPs were the most common health professional referred to (65 responses), followed by social prescribing link workers (57) and pharmacy (56).

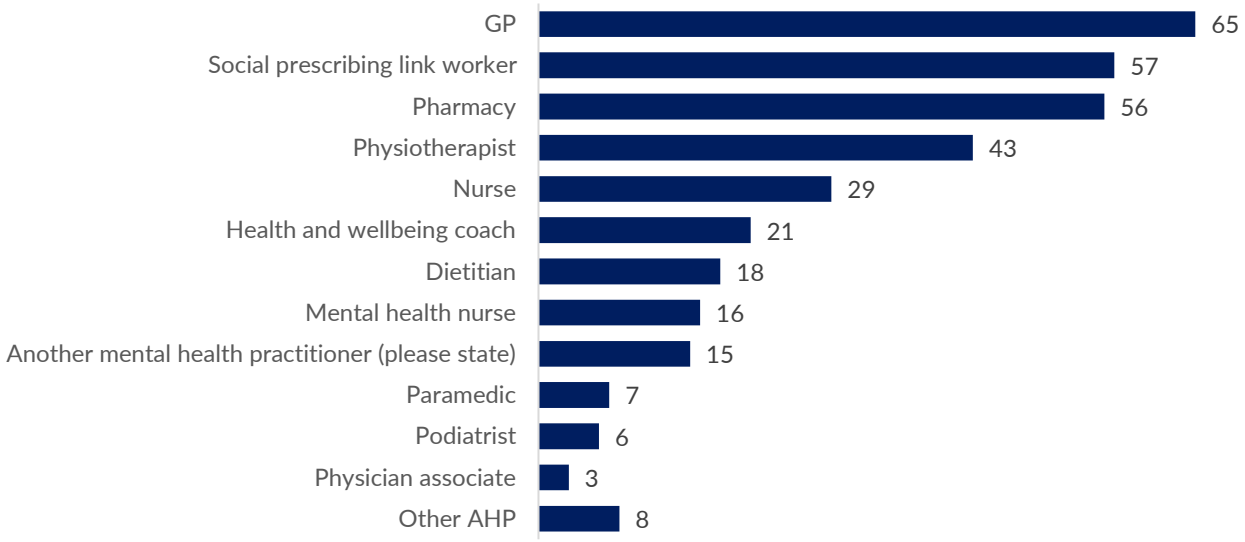


**Figure 18 Other primary care services that occupational therapists refer into (n=102)**

Referrals were also common outside the primary care team, with 93% of respondents saying that they sometimes or often referred patients to other services outside or primary care (see Figure 19).

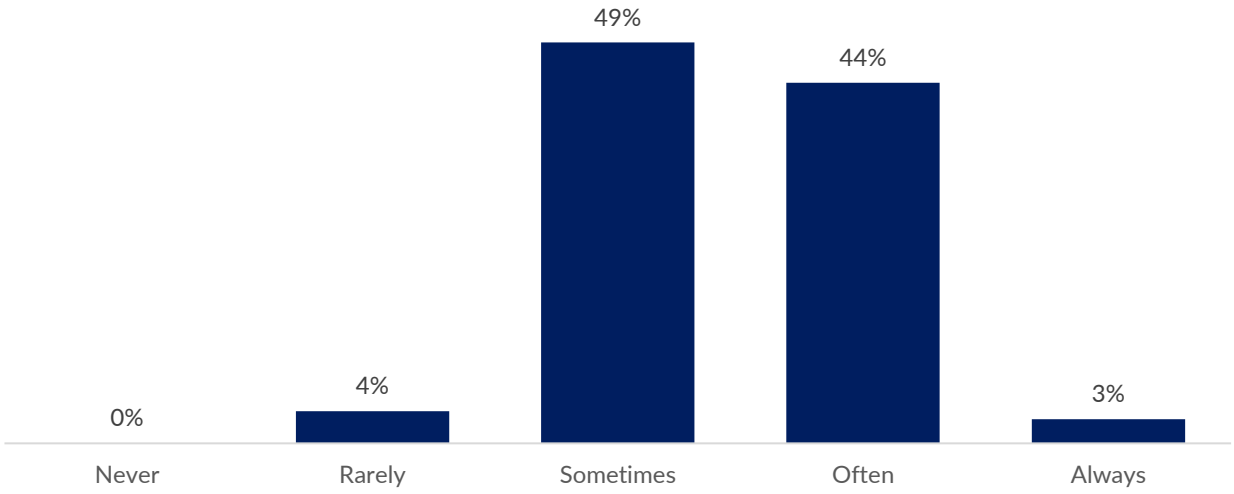


**Figure 19 How often occupational therapists refer patients to services outside of primary care (n=102)**

The main services outside primary care that occupational therapists referred to were social prescribers (outside primary care) (45), memory service (45) and charities (45), closely followed by physiotherapy (44) and mental health services (43), see Figure 20.

The overlap with some types of health services within and outside of primary care may indicate that the inclusion of these in the primary care team varies in different locations.

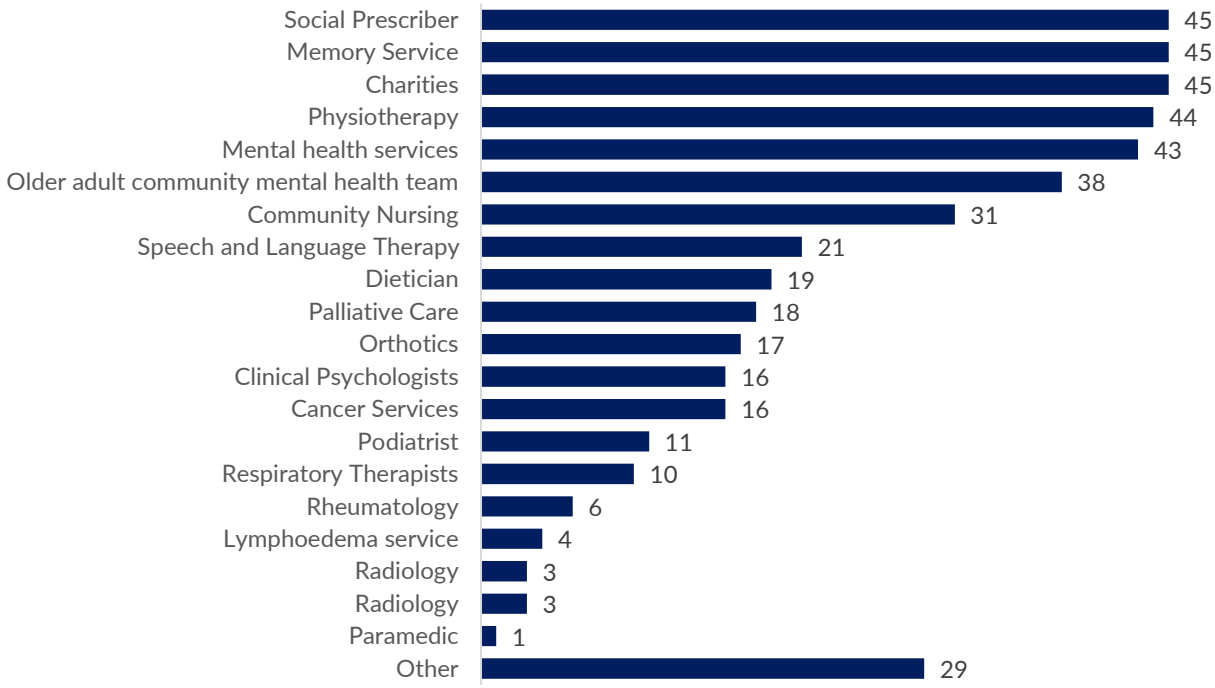


**Figure 20 Other non-primary care services that occupational therapists refer to (n= 102)**

Survey respondents were also asked about the types of outcome measures they used with patients to assess progress and gauge patient outcomes. These were considered across several types:

- Multi-domain outcome measures – used to assess outcomes across several factors
- Frailty outcome measures – focused on assessing patient frailty
- Environmental outcome measures – used to look at outcomes based on a patients' environment, such as work or home
- Psychological outcomes measures – focused on the mental health and wellbeing of patients.

Within Multidomain outcome measures, the most common outcome measure that was used was the Canadian Occupational Performance Measures (COPM) (COPM, no date), with four occupational therapists always using this, 12 often using it, 16 sometimes using it and three rarely using it (see Figure 21). However, there was a lot of variation in tools used, and for all of the options more respondents reported never using it than having ever doing so.

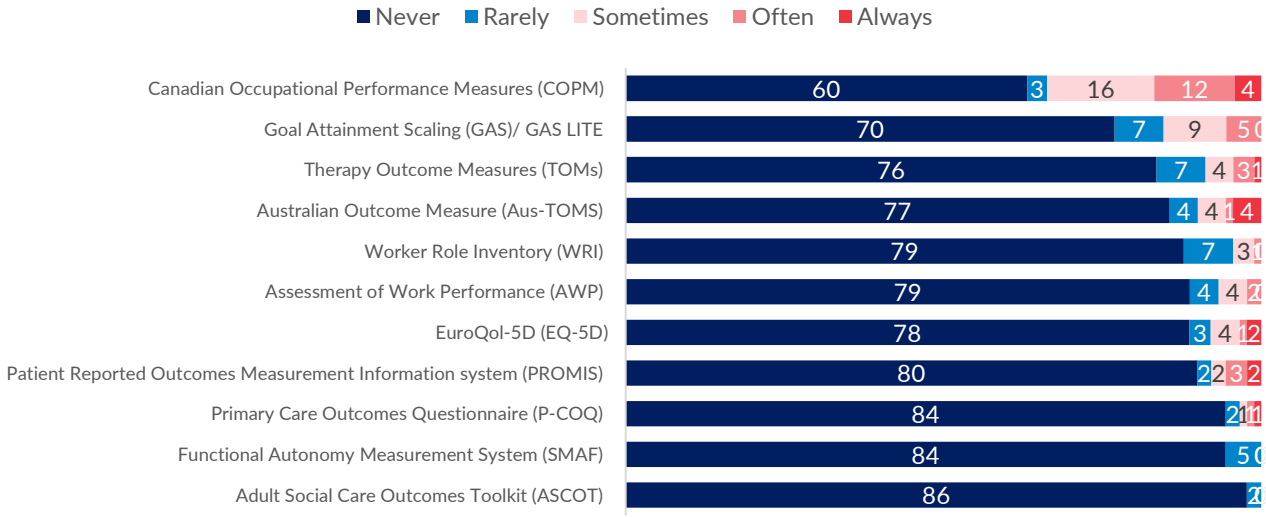


**Figure 21 Use of multi-domain outcome measures**

The same pattern of use was also found in frailty outcome measures, with the clinical frailty scale (British Geriatrics Society, 2021) being the most commonly used by survey respondents (two using it rarely, six sometimes, ten often and 17 always), but still with 60 occupational therapists reporting never using this, shown in Figure 22.

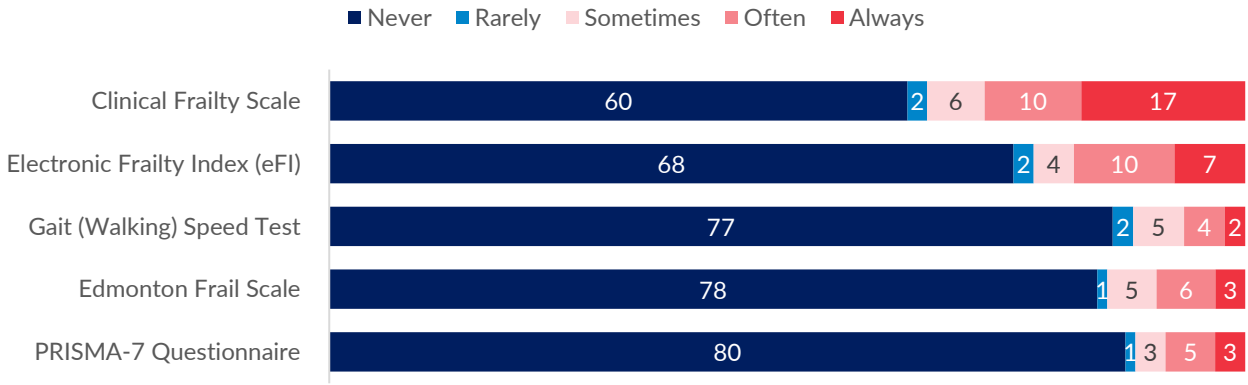


**Figure 22 Use of frailty outcome measures**

The most commonly used motor/functional ability outcome measures were the Time Up and Go (TUG) test (Zeltzer & Zaino, 2008), and the Barthel Index (BI) (Mahoney & Barthel, 1965), shown in Figure 23. The TUG test was sometimes used by eight respondents, often used by six, and always used by one respondent. The BI was sometimes used by seven respondents, often used by five, and always used by one respondent.

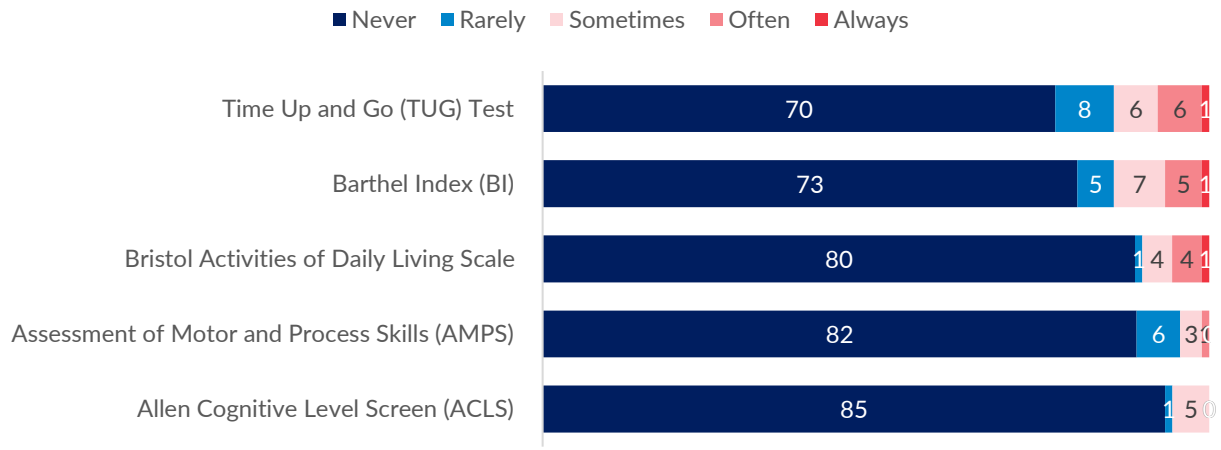


**Figure 23 Use of motor/functional ability outcome measures**

With environmental outcome measures, the Work Environmental Impact Scale (WEIS) (Corner, et al., 1997) was used more often than the Residential Environmental Impact Scale (REIS) (Fisher, et al., 2014), shown in Figure 24, but both were still only ever used by less than half of the survey respondents.

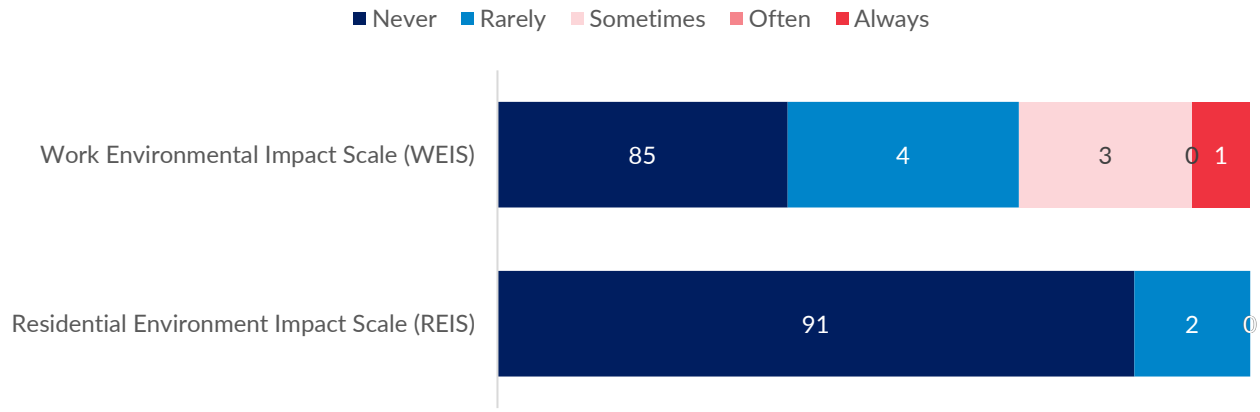


**Figure 24 Use of environmental outcome measures**

Only in psychological health and wellbeing outcome measures were some of the tools available used by more than half of the survey respondents, shown in Figure 25. Both the Generalised Anxiety Disorder assessment (GAD) (Naeinian, et al., 2011) tool and Patient Health Questionnaire (PHQ-9) (Kroenke, et al., 2001) tool were used by more than half of the survey respondents.

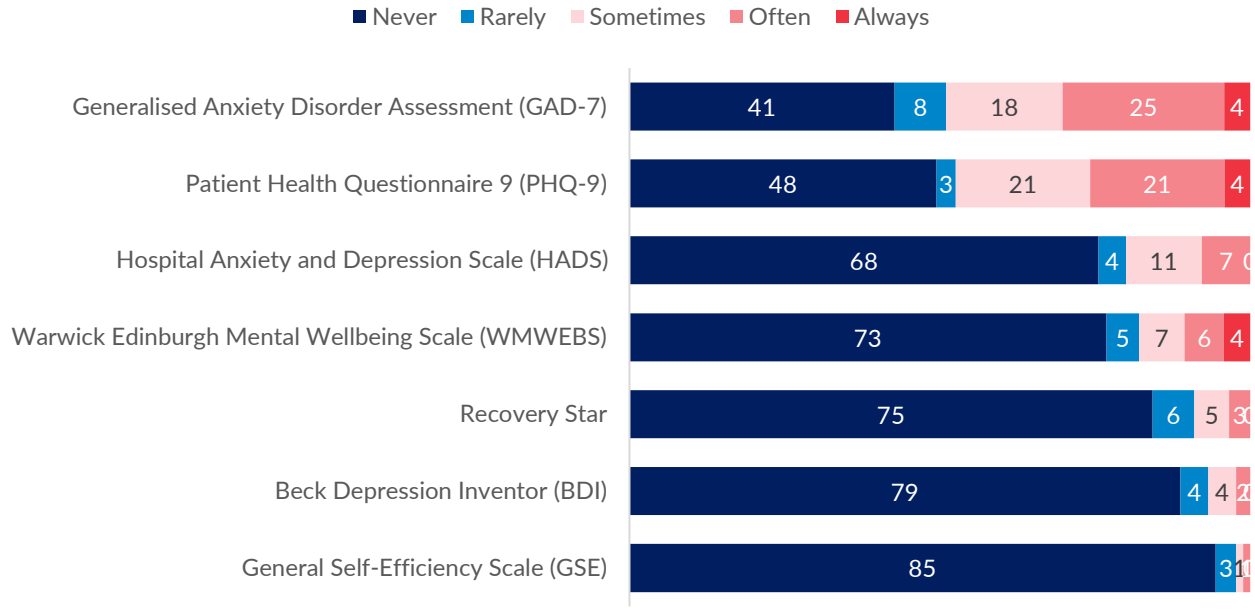


**Figure 25 Use of psychological health and wellbeing outcome measures**

## Workforce challenges and solutions to working in primary care

Finally, survey respondents were asked a series of questions about the workforce challenges of working in primary care, as well as the solutions to these.

The challenge that survey respondents most said they experienced sometimes, often, or always was the shared understanding of the role of an occupational therapist across the wider primary care team, shown in Figure 26.

Despite facing challenges, most respondents felt that they were able to find solutions to challenges they experienced in practice, shown in Figure 27. Most said they were often able to find solutions (51%), while 28% said they sometimes could and seven percent said they always could.

The survey also used a free text question to ask what solutions they were able to use for these challenges. Most solutions that were suggested focused on the main challenges that had been identified. In particular around the shared understanding of the role of occupational therapy in the primary care team, the clarity of purpose around the role, and the readiness of structures and pathways as well as of other services to support occupational therapy. The solutions that respondents reported using included educating colleagues about the role of occupational therapy, including around making good referrals. Key ways of doing this that were identified included speaking

to colleagues, being co-located in GP surgeries, attending regular meetings (both formal and informal), and developing relationships with those key members of the team. Several cited getting backing from senior staff, such as practice managers, and offering feedback to GPs and other AHPs on best practice for making referrals, as well as asking for feedback on their own ways of working. Some respondents also used measures of patient outcomes and/or patient feedback to demonstrate their importance to colleagues.

Peer support was cited as an important solution by many respondents across multiple aspects of the workplace challenges. This included sharing ideas, information, training, and interpersonal support with a wide range of peers. For some this was predominantly other occupational therapists in their own team or in their local area who were also working in primary care. For others, this support was drawn more widely, for example outside of the immediate local area, or drawn from colleagues working in secondary care.

Other important solutions to workforce challenges focused on the need for ongoing training and development opportunities, supervision and management, and the challenge of a manageable workload. Solutions that respondents reported around these aspects were less consistent but included working proactively and within a wider network of peers and support to find opportunities for these. Workloads were also managed by setting expectations within the primary care team, as well as through using, improving, or creating systems and processes to improve time efficiency.

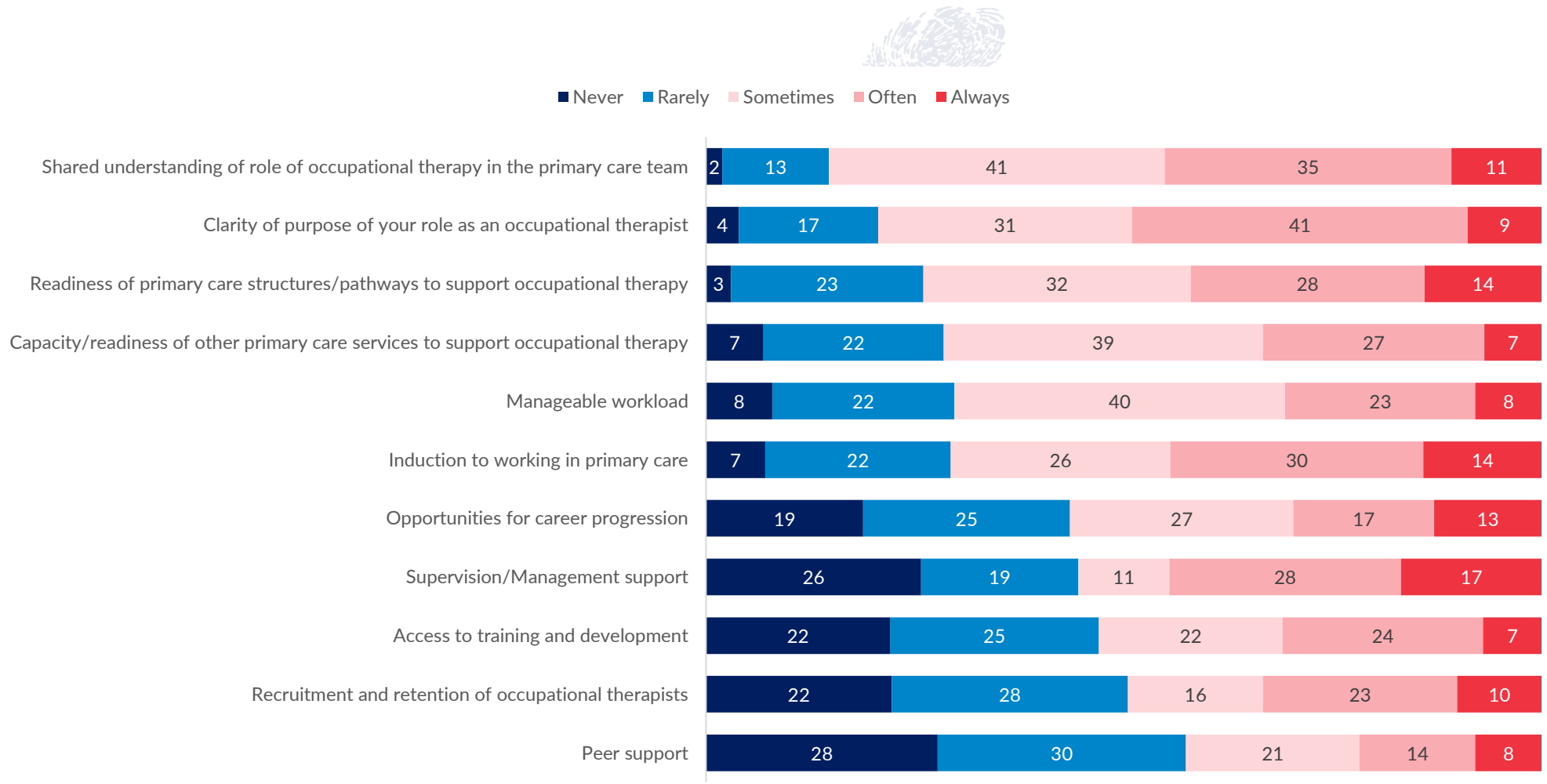


**Figure 26 Experience of challenges in primary care**

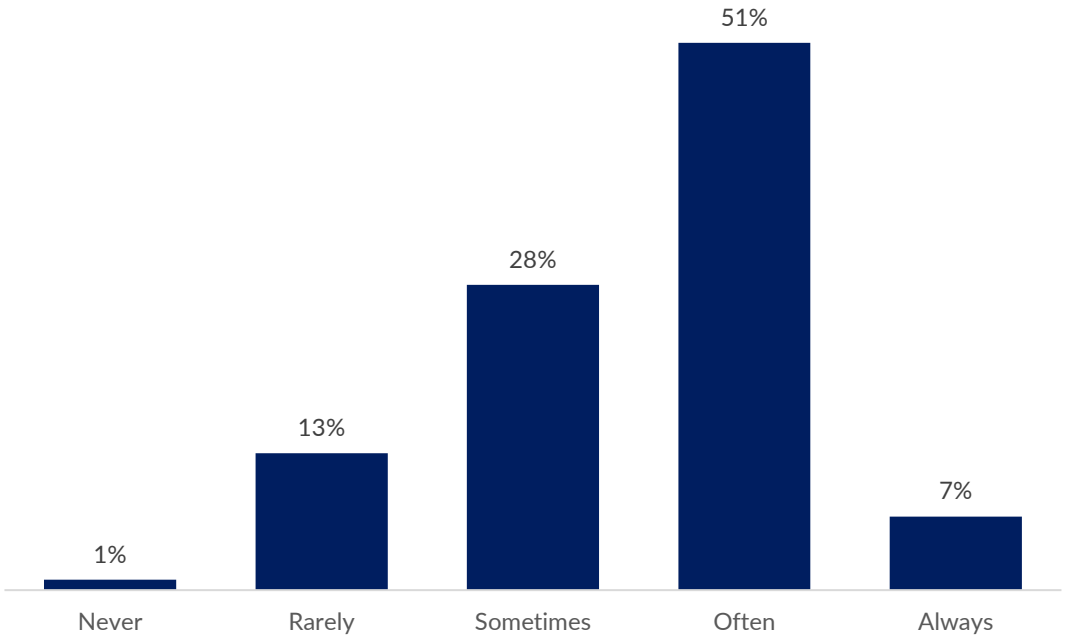


**Figure 27 Ability to find solutions to challenges in primary care (n=102)**

Most survey respondents felt they were able to meet the needs of patients sometimes (ten percent of respondents) often (82%) or always (seven percent), while no respondents felt they could never meet the needs of their patients in primary care (see Figure 28).

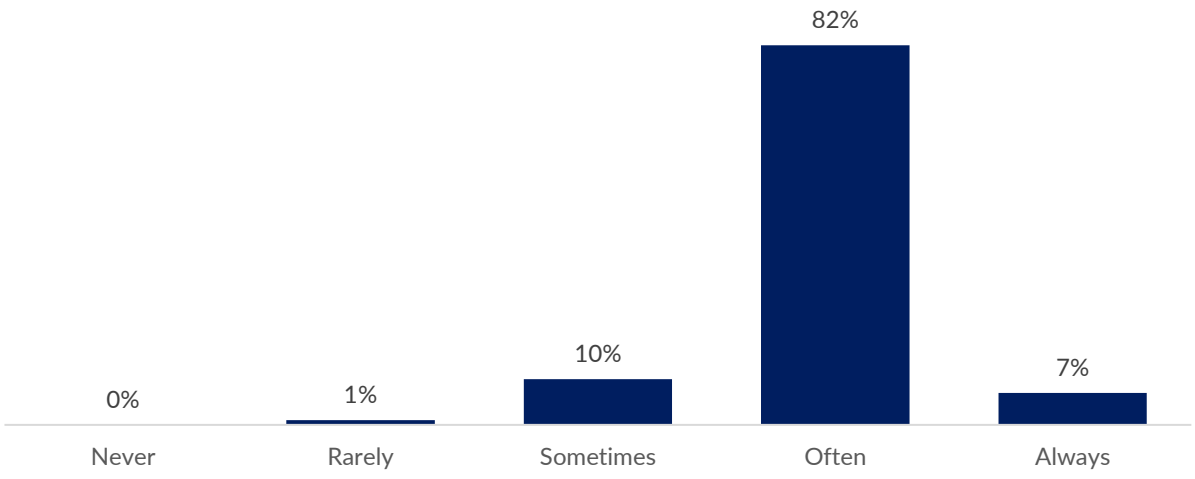


**Figure 28 Ability to meet needs of patients (n=101)**

When asked about the overall experience of working with primary care colleagues, most of the survey respondents felt that this was positive (44%) or very positive (36%), shown in Figure 29. 17% felt this was neutral, and just four percent had a negative or very negative experience.

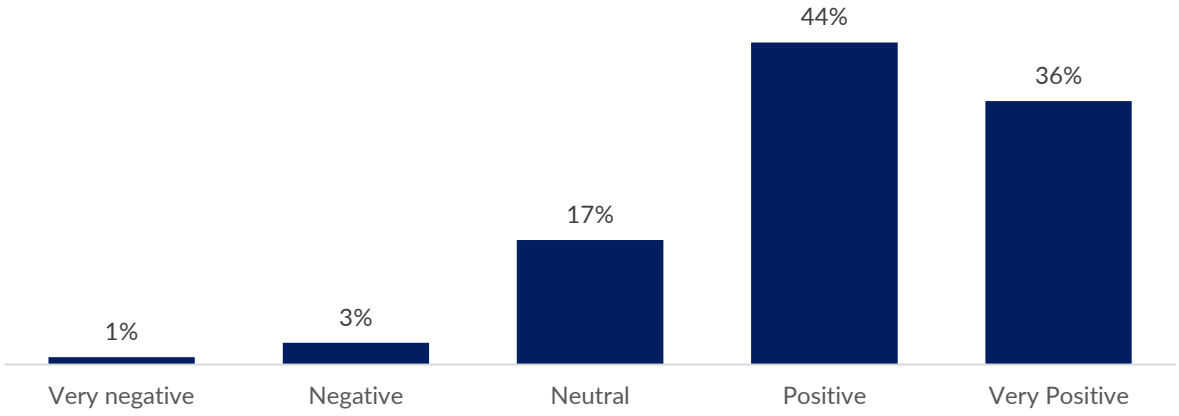


**Figure 29 Overall experience of working in partnership with primary care colleagues (n=101)**

## 4.2 Appointment data

Summary data of the number of appointments from the research sites for a year are shown in Table 5, including all types of appointments (face to face, online, phone). However, each location had differing numbers of involved GP practices, of different sizes. Some of the occupational therapy teams were a single member of staff, while others had a small team of staff. Therefore it is difficult to get an understanding of the average number of appointments per full-time staff member.

Because of this data limitation, it is unclear what the number of patients seen per year per occupational therapist typically are. It is also unclear how this relates to the number and intensity of appointments, and the type of setting that the work is done.

**Table 5 Occupational therapy appointments with over 65s in 2022**

| | |
|---|---|
| No. appointments in 2022 with over 65s | 1,342 |

## 4.3 EQ-5D-5L data

In total, EQ-5D outcomes data were available at first contact (a baseline level) and discharge from occupational therapy care for 77 patients, where these scores were matched at an individual level.

Across the matched pairs of pre- and post- data for 77 patients, the average (mean) score improved from 13.2 to 10.1. Most patients (n=60) saw an improvement (their score decreased from pre- to

post-), while a further 12 saw no change. Just five patients had a worse (increased) score from entry to exit point of treatment. Patient scores pre- and post- occupational therapy intervention are shown in Figure 30.

This reduction in EQ-5D score indicates improvements in quality of life for patients seen by occupational therapists in primary care settings.

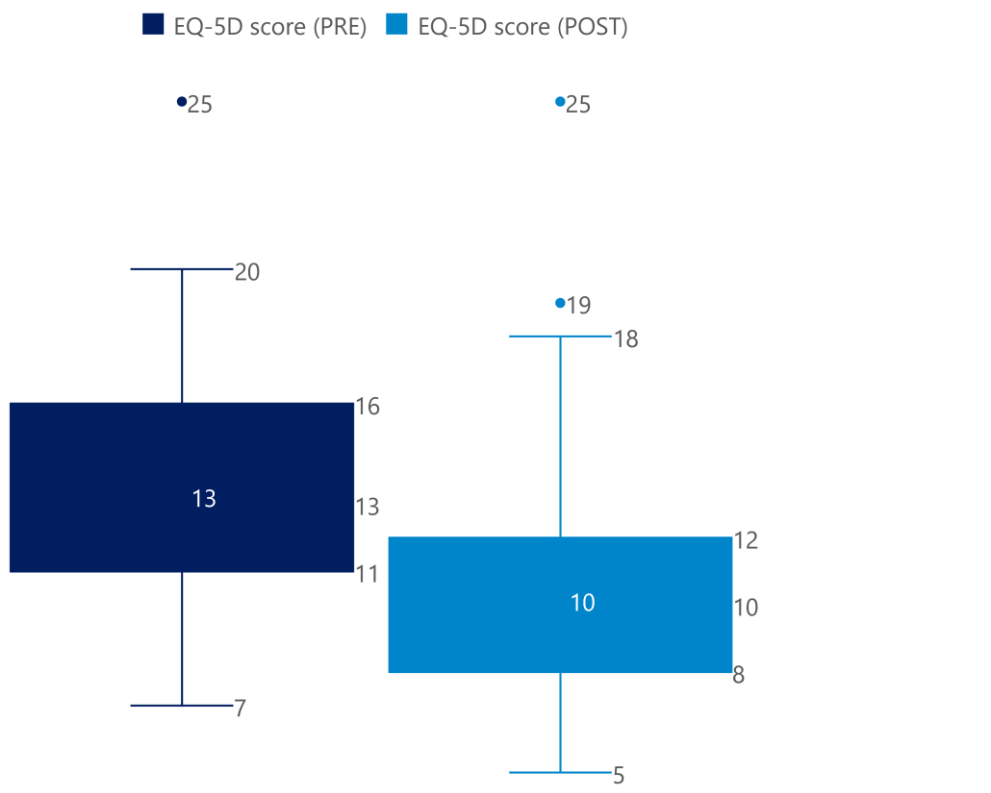


**Figure 30 EQ-5D scores for sample of patients, pre- and post- occupational therapy intervention (n=77)**

## 4.4 Patient perspectives

This section introduces findings from the qualitative interviews conducted with patients and staff at participating sites. A range of staff in different job roles were interviewed including occupational therapists, practice managers, GPs, physiotherapists, mental health practitioners and advanced nurse practitioners.

### Overall experience of care from the occupational therapist

All 17 patients reported positive experiences of receiving care from their occupational therapist. Every patient interviewed had received a home visit and this was reportedly an element of care which made them feel listened to and reassured. Patients reported feeling that the occupational therapist had fully understood their needs and would help them to remain independent in their own home. Some of the reasons patients gave for such a positive encounter was the friendliness of the occupational therapist with many noting that they 'put them at their ease' and was easy to talk to. This was found across all fieldwork sites.

*"She came to see me at home. Really helpful her coming to my home. She has been a godsend to me." (Patient)*

*"(OT's name) has helped with my hip – she brought me different things to help me. I was carrying my meal into a room with a tray, and she brought me a kitchen trolley and it has been marvellous. She brought me a bed – it's like a deckchair effect – so I'm not lying flat in bed... and I can get easier – she couldn't' do enough... she rings me to say are you ok?" (Patient)*

This quote demonstrates the breadth of help the occupational therapist was able to offer this patient. It also speaks to how through a home visit, the occupational therapist was able to assess different aspects of the patient's life and daily activities, highlighting the holistic, person-centred approach of occupational therapy.

### Previous experiences of occupational therapy

Only one patient had experienced occupational therapy care prior to this study and was able to compare her previous experience with her current experience of receiving it via her GP surgery.

*"I think it has worked very well – compared to when I was dealing with my mother. I had to deal with a lot of hospitals to get occupational therapy services for my mother. From my point of view things have worked very efficiently. She rang me when she said she would, she phoned when she said she would etc. Nothing to be improved." (Patient)*

This quote outlines the ease that this respondent reported when she received occupational therapy currently, compared with her previous experience. In our study, almost all the interviewed patients reported not knowing what occupational therapy was prior to their current engagement with their occupational therapist through their GP surgery.

*"Well I was very impressed because it came out of the blue – I didn't expect it at all. It was a great surprise. I am glad it did of course." (Patient)*

## Speed of accessing support

All patients commented on the speed of receiving support from their occupational therapist and how this had been a welcome surprise. This included the time between being referred to the occupational therapist by their GP (in most cases this was a period of a few days to a week) as well as following the home visit, the arrival of any equipment the occupational therapist had ordered for them.

*"I asked if I could have an aid for the toilet and then [occupational therapist] contacted me – and within a day or two I had the aids and the little trolleys and also a gripper to pick those things up." (Patient)*

Patients expressed surprise at the equipment that the occupational therapist was able to suggest. They talked about tasks in their lives that they had struggled with, being resolved by a piece of equipment that they had not known existed prior to the home assessment.

*"She has been nothing but a help to me. She is easy to talk to which immediately puts you at rest. She is there to listen and to help. If you come up with things that you think you might need. She comes up with suggestions. Cup of tea machine - that means you're not tipping hot water over your hand... long handled sponge and a toe washer... all these things make a difference – they keep people like me who don't want to be a burden – I have been independent, and I don't want to be a burden – I want to do stuff myself.. The last thing I want to do is go into a home." (Patient)*

One patient explained how a daily task which had become problematic, was resolved quickly by having appropriate equipment provided by her occupational therapist.

*"She has done loads and loads of things – I was having a problem getting socks on – (OT) brought an apparatus and showed me how to use it and what to do – it has been a blessing in disguise."*
*(Patient)*

Patients received a range of equipment following their home assessment with their occupational therapist. Some of the equipment mentioned in interviews included toilet aids, shower benches, grab rails, a chair for the bath, a hot water dispenser and one patient had their settee raised to enable them to get up more easily.

## Wider lifestyle improvements

Alongside the practical help that the equipment provided, patients spoke of the ways the home visit allowed the occupational therapist to aid them in other areas of their lives. Some spoke about being able to take up hobbies which they had abandoned. For example, one patient had not been able to access his back garden due to not feeling safe to walk down his steps to the garden. The occupational therapist installed a grab rail and now he was able to sit outside in the garden and feed the birds – an activity which made a great difference to his mental wellbeing.

*"She got me equipment - like a handrail outside my back door which has helped me get out into my backyard. She went through the council and got a team out to measure and fit it. I can now get out to the backyard without any problems. I have Thalidomide – she got me the rail. It has made one heck of a difference. I love the outside - I was a gardener and a groundsman all my life – now I love sitting outside – I take great pleasure feeding the birds. To be able to get out there and feed them when I need to, it's a pleasure, it's an honour." (Patient)*

*"On her first visit she was very thorough – she assessed my mobility in terms of getting in and out of the bath – going up and down the stairs – she asked me about things that I'd like to do - which was gardening, so she got me some kneelers. She gave me a tip for going up and down the stairs."*
*(Patient)*

The two quotes above outline how the occupational therapist performs a holistic assessment of a patient's current way of life, as well as asking them about activities they would like to continue to do.

In the second quote, the patient talks about a wish to do some gardening. Later in the interview, the patient spoke about receiving some 'kneelers' which enabled her to get out into her garden again.

A carer described how the equipment the occupational therapist had provided for her mother-in-law had impacted her whole experience of getting around the house, not just one area.

*"She got her a wheelchair/ the settee being raised – had a look around the house – suggested a walking frame – we already had a stair lift fitted but she is struggling to get on and off it – so we had handrails put on walls struggling to get on and off the settee – so we raised the settee – a frame to get her on and off the toilet. She has a shower seat which really helps." (Patient).*

## Holistic care and reassurance

All patients appreciated the holistic care that they received. They felt the home visit enabled the occupational therapist to understand what was important to their physical and mental wellbeing. All patients spoke about the reassurance they felt from having the occupational therapist's phone number. They reported that they felt able to call their occupational therapist if they needed them and that if they called them, they would always receive a call back or a visit in a few days.

*"It was also very nice of (OT) to leave me her telephone number - it made me feel very reassured. I won't hesitate to contact her again if I need to." (Patient)*

Several patients spoke about feeling cared for and valuing the personal, one-to-one aspect of the service.

*"Good – if there is a better word than good I'd use that – she makes me feel as though she cares as well.. She makes me feel as though I'm the only person she cares about." (Patient)*

The reassurance that having their occupational therapist's number led some patients to report that they would not hesitate to contact their occupational therapist if they needed help.

## Support offered beyond equipment

Patients spoke about the different kinds of help that they had received from their occupational therapist. One carer described how their occupational therapist had helped them to obtain a Blue

Badge which meant they could now take her mother out for a day trip. Another patient described how, as well as equipment, her occupational therapist had helped her apply for a carers allowance which meant she could afford a cleaner.

*"It means I can get a cleaner too (she helped me get an attendance allowance) you have to have medical confirmation – they ask when did you see a GP? I hadn't seen a GP for ages so couldn't apply – but said I'd seen (OT's name) and it worked – Different forms of help – it is something that she is doing in the background". (Patient)*

The same interviewee also spoke about how the occupational therapist had referred her mother into local physiotherapy and dementia day care. The interviewee had not been aware of this service and reported that it had impacted on all their lives in a positive fashion.

*"To be totally honest, it's been absolutely brilliant. We've had phone calls with her regularly. She has referred us to physiotherapy and dementia day care that we can take her to for the day. She has helped us get her a Blue Badge so I can take her out for the day." (Patient)*

These quotes demonstrate the variety of ways occupational therapists can support their patients to remain in their homes beyond the provision of equipment around the house.

## What would patients do without the service?

When asked what they would do if the occupational therapy service via their GP practice was no longer available, all patients said that they would have to make an appointment with their GP. They felt that this would lead to long waiting times.

*"Well, I think I would have troubled the doctor or the surgery" (Patient)*

One carer said when asked that they would have done without the occupational therapy service,

*"I have no idea. We would have just struggled through, and it would have been a nightmare." (Patient)*

Another patient, in response to this question answered that she thought it would have had an impact on her mental health if the role did not exist.

*"I don't know – I think I might have gone into a bit of a depression – I wouldn't be myself – I couldn't have coped physically with things (the toilet) I probably would have tried to acquire these things myself – but it would have taken longer – everything she ordered for me arrived quickly – I wouldn't be in the frame of mind that I am in now definitely – I still do a lot – I'm on the Board of Governors at my local school – I am busy in the community – using the wheelchair that (OT) suggested – helped me get there – I wouldn't have been able to do that." (Patient)*

We interviewed three carers of patients who had received care from occupational therapists in our study. One carer described how she did not think she would have been able to cope without the help she had received from her occupational therapist.

*"From my point of view, I don't know how I would have coped without the bath chair. It has been a massive relief for me and given reassurance for her (mother). (OT) is great at getting back to me – usually she gets back to me on the same day." (Carer)*

When asked all the patients interviewed reported that they would recommend this service to any of their friends or family who needed an occupational therapist.

## Areas for improvement

Patients did not identify any areas for improvement in relation to the care and support they had received from an occupational therapist. The only issue that some patients identified was that some thought the service should be better advertised and that patients should be made aware of it more widely. All patients said they only heard about it when they attended a GP appointment, and the GP referred them to the occupational therapist. One patient was so keen to spread the word about the positive experience she had that she wanted to book her occupational therapist to come and speak at a group she organised in the village where she lived.

*" I was going to mention that I belong to a group of ladies who meet once per month – I am supposed to be in charge of getting speakers to the group – so I've suggested getting (OT) to the group to speak." (Patient)*

This quote highlights the trust and good relationship that has built up between this patient and the occupational therapist. The patient reported that none of her friends knew about the service which

was why she was trying to organise a speaking event. A carer spoke about her concern that others might not know about the service and wished for it be more broadly advertised.

*"The only criticism I have is that the doctors never told us about it – it is not put out there that this is the help that we can receive." (Patient)*

## 4.5 Practitioner perspectives

The qualitative interviews conducted with staff generated rich insights and themes. There were differences in findings across the three fieldwork sites as well as between staff roles. The findings are presented below.

### The impact on staff of providing an occupational therapy service from primary care

All staff, across all sites reported that they found having an occupational therapist on the team helpful and valuable. Some staff spoke about how having the role on the team encouraged and improved communication within the team.

*"I think it's fantastic – it allows communication across different roles, you can speak to the occupational therapist directly, it avoids a lot of messy contacts and trying to get information. It makes it easier for us and more personal for the patients." (Care Coordinator)*

Other staff members spoke about how the role reduced their workload through the holistic, place-based approach of occupational therapy care.

*"I think she is excellent – she sorts stuff out –so it encourages you to use her more and more – she is also extremely competent. She reduces your workload by going out and assessing things. She attends meetings and gives additional health information. She will always get involved." (Physiotherapist)*

### Providing a holistic service

Staff interviewees felt that having an occupational therapist on the team enabled the offer of a full, holistic service to patients. One interviewee said,

*"I am very patient centric – we want to do the absolute best for our patients – going home and knowing that I've been able to pass the patient to the occupational therapist for provision of an aid – or even if it's just to resolve a small problem. Then I know that they are not going to have to come back to us in a few weeks' time. Because they are older – yes, they are high-users, but they are also the make do/ put up with generation. Going home knowing that we've made their lives easier – has a massive impact on my wellbeing." (Paramedic)*

An occupational therapist interviewed in our study reflected on the impact she felt she had on the team.

*"One GP just said, 'I worry less if you're involved'. When I go out and see a patient and I cover that full holistic assessment – the GP can feel reassured that patients are really having that comprehensive holistic assessment. I am not medically trained –but there is so much that presents in GP practice that is the social model of disability. That is what GPs benefit from - being able to hand over the complexity of older adults ageing. GPs don't have the time or the skill to do it. They say that we save them time – not knowing how to refer on – it can take a GP ages to work out how to refer somebody. Patients once they've seen me, they can contact me directly – that is the real difference to any other service – most services they discharge you and that's it. With me, they can contact me directly, so they don't have to go via the receptionist." (Occupational therapist)*

A GP spoke about the impact that having an occupational therapist on the team had on her.

*"I get to stop pulling my hair out – it was frustrating because you could see somebody had these needs and you were just directing them to the internet. So, I didn't really have anybody to refer them to. There was a service through social services with an inordinate waiting list – just frustration that you didn't have somebody you could pick up the phone and say, 'can you help?" (GP)*

The ability to provide a service to patients that was preventative and person-centred contributed to respondents' job satisfaction.

One GP noted how the addition of the occupational therapist role to his Primary Care Network enabled the delivery of an integrated care model for patients. This respondent spoke of a time when he identified an unmet need for his patients but had no idea that an occupational therapist could fill it.

*"I think it's brilliant, I would go as far as to say it's the best thing I've done as a PCN! I feel really proud of the service. I think it fills an unmet need – the idea came before we thought about having an occupational therapist in the role – recognising that patients that were housebound with high levels of frailty – patients who are in a care home get a very good deal. We saw a gap. We didn't know that an occupational therapist would be able to fill that role. We only went to an occupational therapist because we couldn't' recruit anyone else (we tried pharmacy). We went for an occupational therapist, and it has proved useful. The holistic service has proved useful – the occupational therapist role has fit in really nicely with the wider MDT – it also plugs in quite well to other partners – so we can deliver integrated therapy with community-based occupational therapy and physiotherapy." (GP)*

## Making appropriate referrals

Several staff interviewees spoke about the value the occupational therapist brought to the team around making appropriate referrals onto other team members as well as fulfilling a gatekeeping role of keeping referrals away from GPs. One occupational therapist reflected on how they performed this function within the practice.

*"So occupational therapists can gatekeep the referral route rather than the patient going back to the GP all the time. A large proportion of what comes back through from the occupational therapist is not medical … this takes a huge load of work off the GP (Occupational therapist)*

One GP reported how she found it useful to have the occupational therapist conduct home visits when she could not.

*"One thing I find important - because I don't want to go out to see if someone is coping – the occupational therapist will go and see them… it turned out that the patient was a hoarder - she will go and look in the cupboards etc… but equally she doesn't overreact – she can assess it – but she can also handle it as well and is appropriate.. She identifies unmet need - she doesn't very often pass it back to me .. if she does then it's appropriate." (GP)*

This quote demonstrates the way in which this GP respondent uses the occupational therapist role as well as recognising the occupational therapist's skill in making appropriate referrals. One physiotherapist described the process of making referrals to the occupational therapist in her practice.

*"Seamless – I've never had any problems. Because she is in-house, I can see her availability and I can put a patient directly into that slot." (Physiotherapist)*

The quote highlights the ease with which the occupational therapist role slots into practice staff routines and that colleagues find the occupational therapist role useful. It also demonstrates how the patient experience can be enhanced by more joined-up IT systems in the GP surgery and interprofessional working.

The improved referrals process led to a faster response time in which occupational therapists could see patients. All staff respondents were aware of lengthy waiting times in the NHS and were grateful to have a service that meant patients would be seen quickly.

GPs were aware that the occupational therapist kept referrals away from them by directing patients to other services within the practice. They spoke about how the occupational therapists had excellent local knowledge gained through working in the community. Occupational therapists also felt one of their main offers to the primary care team was their skill and knowledge of how to refer appropriately. They identified their knowledge of the community sector as the reason why they made more appropriate referrals than colleagues in the GP surgery team. They viewed this aspect of their role as crucial to ensuring patients were seen by the right service at the right time, as well as contributing to a reduction in workload for their general practice colleagues.

## What would happen if the role was taken away?

When asked what they would do if the occupational therapy role was removed from the GP surgery, respondents said that they would have to refer to secondary care and/or social services. They all felt that this would result in longer waits for their patients, possibly resulting in a deterioration in their physical condition and their mental wellbeing. An occupational therapist responded to this question by outlining what she thought would happen if the role (based in primary care) did not exist.

*"The biggest impact would be that we already have extremely long waits in social services for OT assessments and those are for more complex aids (anything that is more costly or adaptation work) if didn't have OTs in primary care all their workload would also go to social services would go to them – that very basic, immediate preventive work – we all know that a lot of patients present late anyway and then they are not seen for three to six months because they are low priority - in six months' time they will be a lot*

*worse... there would then be a massive disconnect with managing a health condition and living with a health condition" – Occupational therapist*

When asked what they thought might happen if the post was taken away, one GP said, that he would still see the patients – but they would be in a worse state and would require more serious intervention by the time he saw them.

*"We wouldn't' be having the proactive work that she is doing – we'd be seeing the patients when they'd had their fall. They would be waiting longer. They would be being referred through the ICT – there would be an unmet need – an occupational therapist can deal with low level mental health needs. Their (patient) care would be more uncoordinated." (GP)*

## Value of additional skill-mix in general practice teams

All respondents spoke about the value that the added skill-mix of their occupational therapist-colleague brought to the team. One physiotherapist described how she worked with the occupational therapist in the practice.

*"She is such a font of knowledge - a lot of the time she is able to resolve issues without them becoming a formal referral. There are a lot of conversations that happen between her and I – she manages demand before it even becomes a formal demand. Sometimes it can be sorted out with a phone call. She works preventatively – If I do a visit and notice that someone could do with her – I can send her, and she can sort it out. She is very efficient and personable she gets things done; she gets things done. If I refer to her, I can see her caseload, I can see her workload and that she has got things done. So, it saves you team time." (Physiotherapist)*

This demonstrates how through a close working relationship the physiotherapist and the occupational therapist work together to prevent an issue escalating into a referral. One GP noted how the occupational therapist's skill set was valuable to her.

*"She is very good at the job; she knows what is available locally and gives a bespoke service. She goes out to them and she offers bespoke help for them. Really useful help that actually works. She often arranges to meet the family and is excellent, she will be very good at calming it all down. She smooths situations." (GP)*

This quote demonstrates how the GP notes the skill set the occupational therapist has in 'smoothing' situations. This echoes the comment from the physiotherapist in the first quote, when the physiotherapist mentions how the occupational therapist can often resolve issues with a phone call. The preventative nature of the role of the occupational therapist in primary care is valued by these two colleagues.

## Knowledge of the occupational therapy offer in primary care

All staff interviewed, except GPs, felt that they had a good understanding of what occupational therapists did and could offer to the team prior to the pilots. GP respondents reported that prior to having an occupational therapist on their team, they did not know what an occupational therapist did. This was highlighted in interviews with occupational therapists who spoke about having to raise awareness among practice team colleagues about the breadth of skills the occupational therapist can bring to the team.

*"I've had to do all the work on helping staff to understand the roles: I did a poster, video, and a leaflet – for staff. GPs are busy – the help has been attending the meetings – an elevator pitch – explaining what we do in a timely way – as time has gone on this element has lessened. As soon as the GP has referred they are like 'wow brilliant' - it's about them experiencing what we can offer – the breadth of our skill base – it's about allowing GPs to be open about what they think we do – most of the time they think that all we do is 'equipment'...after the first referral from a GP – the referrals come thick and fast" (Occupational therapist)*

All GPs reported that now they had learned what an occupational therapist could contribute to the team, that they would 'not be without one' on the team. One GP wanted to send a particular message to RCOT.

*"Please let them know that I didn't really know what an occupational therapist did – now I do, I can't do without one. In the beginning I thought it was just handrails and toilet aids. I didn't realise it was so holistic." (GP)*

## Future role for occupational therapists in primary care

Some interview participants spoke about what they saw as a future role for occupational therapy in primary care. One GP who admitted to not knowing what an occupational therapist did, prior to this service, commented that in his practice, they now appreciated that occupational therapy was 'the only truly holistic service' and foresaw a role for the occupational therapist as head of the Multi-

Disciplinary Team (MDT). This respondent felt that it was the only role that had oversight over all the services and that knew how to refer 'properly'.

*"I think the story is interesting in that I had not thought about an occupational therapist at all – we identified a gap and didn't know what an OT could do – it's been amazing. RCOT should think about the potential for an occupational therapist role and leadership around an MDT – the way the role is very holistic – other PCNs have identified that the occupational therapist role is well-placed to take on that leadership role in MDTs in PCNs." (GP)*

### Changing the nature of practice

Some interviewees spoke about the ways in which the occupational therapist had impacted on their clinical practice. One GP spoke about how she had changed the way she asked questions, after seeing how the occupational therapist took notes.

*"The occupational therapist has changed the way that the practice responds. I always used to say 'are you coping at home' now I ask individual questions – who is cooking? How are you getting up and down the stairs? How do they remember to take their pills? How do you remember what you are taking? It is separating it out... I've read what she has written in the notes, and then I've thought 'oh that's a better question to ask' and so now I ask the sort of questions I know that she would ask...she has definitely changed the way I practise. And the way the whole team responds to patients now." (GP)*

## 4.6 Occupational therapists' perspectives

Seven occupational therapists working in the fieldwork sites were interviewed as part of this project. They were asked to reflect on their experiences of providing occupational therapy from general practice. All occupational therapists enjoyed their role and felt that delivering occupational therapy care from general practice was the right place for occupational therapy to be. They viewed their role as performing a preventative service and one that sought to allow people aged 65 and above to live independently in their own homes for longer. One occupational therapist said that she liked primary care, because she could use all her skills. Another commented on the satisfaction she felt, once primary care colleagues understood what an occupational therapist could add to the team.

*"Personally, I find the job rewarding – once the GPs and the additional role staff realise the full impact of the OT offer – I felt the sense of being valued very quickly. It is a very fulfilling role in that regard. If you have the OT as a product – it's so easy to see what impact you can make once they have the opportunity to try it." – (Occupational therapist)*

Occupational therapists participating in the study were asked to reflect on barriers and enablers to the role in primary care that they had experienced.

## Visible presence in the practice

All occupational therapists we interviewed were asked what had helped them to establish their role in primary care. Regular and informal contact with colleagues was commonly identified as a key enabler of implementing occupational therapy and all interviewees commented on the importance of attending the MDT meetings. It was felt that through MDT's the contribution of occupational therapy to the wider primary care team was most visible and that advice around referrals was particularly valued.

*"Attending MDTs really helps to facilitate uptake. It's also about profile – I'm linked specifically to one GP practice where the clinical director is based." (Occupational therapist)*

The challenge of 'getting your face known' in the practice was frequently mentioned however and whilst some occupational therapists had permanent desk space in the practice, others had to maintain regular informal contact through 'dropping in for lunch' with the team once per week. Occupational therapists said that this helped generate referrals as colleagues did not forget about them.

*"People knowing your face – physically seeing that person is massive – better than an email" (Occupational therapist)*

Another occupational therapist mentioned the importance that a staff room, or shared space affords. They talked about an informal space where people can exchange information or just chat however where this is not available some occupational therapist noted particular challenges.

*"I think one of the challenges is getting your face known in the surgery – one surgery I have never met a GP yet after two years. We are separated at opposite ends of the building." (Occupational therapist)*

## Turnover of practice staff

Occupational therapists spoke of the challenge of high staff turnover in general practices, particularly among locum GPs. Occupational therapists reported investing a lot of time and resource into being present in the practice, attending meetings and telling colleagues how best to use them, only to be confronted by high staff turnover. One occupational therapist spoke about having to repeat this process every time a locum GP left the practice and a replacement one arrived. This was noted by a practice manager in our study who commented that this applied not just to locum GPs but to reception staff too.

*"At the start it took a while to establish and get people aware of what it is she does, so there was a bit of work on communication and briefing admin staff at practices, which is ongoing to an extent as reception staff have relatively high turnover." (Practice Manager)*

## Confidence working alone in the community

All occupational therapists noted that the role can be lonely and might not suit a newly qualified graduate. One occupational therapist said,

*"I work well on my own, but it depends on how much support is available because it can be lonely." (Occupational Therapist)*

This highlights, that support is welcomed and can be available, but the occupational therapist needs to be confident working without a physical team for much of the day. An occupational therapist spoke of the challenges this posed for recruitment.

*"They need to be an appropriate grade because they have to work on their own – that's a barrier." (Occupational therapist)*

The challenge, this interviewee mentioned, was the role being at an NHS agenda for change band six skill level, rather than a band seven skill level. At a band seven, the interviewee reported that they would not have a problem recruiting.

## Contractual arrangements and funding

Differences arose between sites on the topic of employment terms and conditions. Some occupational therapists reported that they suffered a loss in terms and conditions when they moved from secondary care to primary care. This was not reported at all sites.

*"Issue around terms and conditions and how we're employed – when you work for a secondary care Trust you get Terms and Conditions, whereas the offer is not as good for PCNs – so there is a compromise to be made there." (Occupational therapist)*

This same interviewee went on to say that,

*"Very good OTs have said no* [to entering primary care] *because they don't want to lose the Terms and Conditions." (Occupational therapist)*

Differences also emerged in the funding arrangements of posts. Some roles were on a one-year contract which occupational therapists felt was a barrier to recruitment. They suggested that changing from a permanent post in secondary care to a one-year contract with a drop in terms and conditions in primary care, would make it hard to recruit. One occupational therapist explained the different funding streams behind the posts.

*"Complexity comes where we've got different funding streams. [OT's name] position is permanently funded through T core monies – so there is permanency to it – [OT's name] post is reviewed every year because it comes under cluster monies. Fragility of funding is the biggest factor [to recruitment]." (Occupational therapist)*

Some occupational therapists remained employed by their original NHS organisations, rather than starting a new contract directly with the GP surgery. Those occupational therapists who remained employed by their original NHS organisation did not report anxiety over the sustainability of the funding for their post.

## Fears of de-skilling

Across all fieldwork sites, occupational therapists reported that among colleagues working in secondary care there was a fear of becoming de-skilled if they were to take a post in primary care.

*"I have heard that some people feel that they may be deskilled a little bit because they are working in a generalist setting. Because you have to spread yourself thinly – especially if they have been in specialist areas such as mental health. People feel that they are not maximising their potential." (Occupational therapist)*

One site reported a challenge in recruiting to band six posts in primary care roles as it was seen as a 'move sideways' that could jeopardise progression. The same respondent reported that they did not experience any challenges recruiting Band sevens.

*"We have a massive problem in* [area] *with Band six recruitment – it feels like in* [other area] *there isn't a problem) but a lot of the more remote areas are difficult to recruit into. There are less rotational posts that go on – so the posts become static so band sixes stay in place. People don't even want to do a sideways move anymore." (Occupational therapist)*

## Occupational therapists' concerns over evidencing the contribution in primary care

Several occupational therapists raised the topic of how they might evidence their impact in primary care. They noted that the preventative work they undertook would not be captured by the EQ-5D-5L tool and were keen to emphasise the long-term impact of the role in primary care. One occupational therapist commented that,

*"It would be nice to have good outcome measures about how we identify our value. I am mindful that we are all doing this differently. It would be nice to have some kind of standardised outcome measures." (Occupational therapist)*

This quote reflects the knowledge that there is variation among occupational therapists around how they collect evidence and the recognition that a standardised measure would be helpful. Another occupational therapist noted the same point about variation in data collection.

*"Occupational therapists have always struggled with proving their worth and their value – we have had to find our own ways that demonstrate multi-faceted outcomes - that takes time and it's complex." (Occupational therapist)*

This quote draws attention to the vacuum around how to measure the impact of occupational therapy based in primary care. The quote illustrates how in the absence of a standardised set of measures, occupational therapists have had to create their own methods of evidencing their worth and value. This confirms the variation in data collection tools and methods this study found at the survey stage.

# 5. Discussion

This section will consider the findings in relation to the five research questions.

## 5.1 The volume of occupational therapy being delivered

There is evidence from both patients and those working in primary care that occupational therapy alleviates pressure and creates capacity within the system enabling quicker access to appropriate care. Whilst caseload size and activity appear to vary substantially, responses to the survey across the workforce indicate that on average occupational therapists maintain a caseload of 30 primary care patients providing between 26-50 sessions of 30-60 minutes per month, including all appointment types, whether face to face, online, or by phone.

In addition, this research identifies that on average 26 new patients per month were taken on by occupational therapists, and 16 patients per month were discharged from occupational therapy care, 49% of patients received between one and three appointments. Occupational therapy therefore can play a substantial role in supporting the delivery of the four nations strategies for primary care.

The range of types of appointments, number of GP surgeries that occupational therapists work with, and the types of interventions and support delivered all demonstrate the breadth of work that occupational therapists deliver in primary care.

The referral type and frequency reported by occupational therapists through the survey results demonstrated that there was strong referral links to other parts of the primary care team and AHPs. This may indicate that occupational therapists in the primary care setting can increase efficiency within the system through enabling direct referrals into other areas of care.

## 5.2 What have the impacts been for patients aged 65 and over receiving occupational therapy care through their general practice?

Delivering occupational therapy services from primary care has been shown through this research to be appreciated, valued and welcomed by patients and carers. Among staff similar levels of appreciation for the work the role can offer to the primary care team are beginning to embed themselves into the areas in which they already operate.

It has been a consistent finding in the existing literature and from both survey and interview data in this research that there is no consistent use of standardised patient outcome tools being used within the field. This will clearly impact upon the professions ability to clearly demonstrate outcomes and impact in the future and develop a consistent and coherent evidence base for occupational therapy in primary care.

Whilst this study has been able to demonstrate an improvement in outcomes using the EQ-5D-5L tool these improvements are typically modest. This however may be due to the limitations of the tool in relation to not being able to capture any preventative care provided by occupational therapists. The sample cohort must also be taken into consideration and given the scope of older adults in this study, maintenance of health or a prevention of deterioration of outcomes may also be seen as beneficial.

While a universal outcome tool in use across all primary care occupational therapy is not currently apparent, there is opportunity for RCOT to build upon its current data and innovation strategy (RCOT 2021) through recommending the use of key outcome tools for use in addition to condition specific assessments of need. Increasing the use of tools such as the EQ-5D across primary care will support future evaluation of the impact of occupational therapy and meet the Royal College's research priorities (Royal College of Occupational Therapists, 2019)

However qualitative findings of impact are more conclusive with patients consistently reporting positive outcomes as a result of the care they have received from an occupational therapist. This research identifies high levels of patient satisfaction with the care provided by occupational

therapists. This is at a time when overall patient experience of their GP practice is declining with just 72% of patients reporting an overall good experience of primary care in July 2022, compared to 83% in 2021 (NHS, 2022). Reductions in satisfaction are linked with increasing difficulty in access to the GP surgery (Doyle, et al., 2023). The findings from this research therefore indicate that increased access to occupational therapy in primary care, combined with overall positive experiences is likely to contribute to increased patient satisfaction.

Patients reported valuing the person-centred, place-based care they felt they received from their occupational therapist. The first appointment with the occupational therapist taking place in their own home may contribute to putting them at ease and allowing them to speak about tasks they struggle with at home.  Patients reported a very close relationship with their occupational therapist. They spoke about feeling listened to and understood and being able to easily make contact should the need arise. The hour-long home assessment appears crucial in establishing feelings of trust and respect between patient and occupational therapist.

Access to enabling equipment, additional sources of support and onward referral were also associated with support for continued independent living within their own homes and, for some, resuming occupationally beneficial activities and hobbies. For some this was directly linked to improvements in wellbeing and life satisfaction. This is consistent with the existing evidence base.

## 5.3 What have the impacts been on general practices which provide occupational therapy care?

There is emerging evidence that occupational therapy within primary care will reduce presentation at GP sessions. Patients interviewed reported that without their occupational therapist working from their GP surgery, they would seek help from their GP. This was also echoed by occupational therapists within the survey with 63% of respondent reporting that, from their experience, occupational therapy alleviates pressure within the primary care system. This indicates the volume of work and appointments that an occupational therapist based in primary care can take on and prevent adding to GPs workload.

The variation in the sizes of research sites and practices within this study and the limited appointment data available does not allow us to draw definitive conclusions as to the resourcing impact on primary care. However, again, the qualitative data indicates an overwhelmingly positive

experience for other staff working within the sector.  Primary care staff commented on the efficiency of being able to directly refer to the occupational therapist, that provided the patient with a faster referral process and added to a good patient experience. The added skill-mix of the occupational therapist within the multi-disciplinary team was also valued as well as the ease with which the role fits into the MDT and makes positive contributions. It also speaks to future roles for occupational therapy within primary care to perform an oversight, multi-disciplinary function. These findings are also consistent with the literature which highlighted the strong relationship building role that occupational therapists can play in team environments. It is through the establishment of relationships within the primary care team that the benefits of occupational therapists making better referrals were realised.

All staff in the study did not want to lose their occupational therapist once they had experienced having them as a team member in the GP surgery. Staff reported how the role was embedded in the team particularly around the referrals process and their contributions to MDTs. This finding indicates early evidence that in the pilot sites and at the time of interview, the role is embedded well. This offers learning to future pilots around the length of time it typically takes to embed the role and ways this might be done more efficiently in future, based on learning from this study.

## 5.4 What are the experiences of occupational therapists working in general practice?

Survey questions and interview responses about workforce challenges highlighted the main areas being a need for wider understanding and purpose of the role; system readiness and capacity for occupational therapists moving into primary care; and a manageable workload.

Occupational therapists in the study reported how when they first started, they had to spend a lot of their time promoting themselves to colleagues and explaining what they bring to the team. GPs in the study reported that prior to the pilot studies they did not know what an occupational therapist did. This finding identifies a gap in knowledge about the offer of occupational therapy to primary care and the need for an awareness raising campaign of the profession's offer to primary care. This is also exacerbated by the use of locum GP's and staff turn-over which requires occupational therapists to continue to educate the wider primary care workforce. We would suggest that this presents clear opportunities for RCOT to support its members in preparing primary care for occupational therapy through increasing awareness and promotion of the profession. We are aware of the RCOT Primary Care drop-ins available for GPs and other professionals working in primary care and attendance at

this should be monitored to identify gaps in attendance by role and specialty over the year. We would suggest the newly developed RCOT Innovation Hub would be an ideal repository for materials and literature that occupational therapists can draw on to share with colleagues when establishing the profession in primary care.

Additional solutions that address these challenges related predominantly to the need for a connected network of occupational therapists, to provide support, training, and share knowledge and ideas. In addition, relationship building and education work with other primary care colleagues was identified as important, as was the need to use systems and processes to increase efficiency and manage time.

Despite these challenges staff reported that they experienced increased job satisfaction when they felt they were able to provide holistic care to patients. This was commented on by all staff interviewed in the study. Staff identified the occupational therapist role as the key factor in providing that holistic care, because staff could refer to the occupational therapist. Increasing staff and team morale can be viewed as an unintended consequence of the provision of occupational therapy from primary care services.

## 5.5 What are the workforce challenges to delivering occupational therapy care from primary care?

Occupational therapists reported concern over how best to evidence their preventative work in primary care services. They were aware that much of their best work remains invisible to current performance metrics (such as the Quality and Outcomes Framework (NHS Digital, 2022)) in primary care.

The need to evidence the impact of the profession is possibly particularly acute given the lack of clarity of future funding and the use of fixed term contracts that some report.  Other workforce challenges faced included fears in relation to deskilling and a lack of opportunities for career progression in primary care. Significantly terms and conditions between primary and secondary care are not consistent across all the UK nations and this presents a substantial structural challenge for some in moving from secondary to primary services. As such this may be a beneficial campaign area for RCOT.

## 5.6 Limitation of the research

All interviewee respondents were recruited by the occupational therapists in the practice. It should be considered that the occupational therapists may have only recruited staff and patients who they knew were likely to have had positive experiences of working with them. This would represent a sampling bias as the patients and staff interviewed may not accurately represent the characteristics of the population from which they are drawn.

While a known network of occupational therapists working in primary care was used to distribute the survey, it is not known whether this is a representative sample of all occupational therapists working in primary care settings. Likewise, those that chose to respond were self-selected, which may limit the representativeness of the survey results as a whole.

Measuring patient outcomes at the research sites using the EQ-5D tool was limiting in that this was not always the primary choice of outcome measurement for occupational therapists. This means that they may have been less familiar with the tool for recording outcomes. It also provides data to compare pre- and post- occupational therapy intervention, which means that within the three months of data collection, not all patients will have had an entry and exit into occupational therapy care, meaning some data were excluded from the analysis due to lack of comparator result. This limitation of only collecting data for three months, rather than a longer time period, was necessary due to the scope and timing of the research.

# 6. Conclusion and recommendations

Developing and improving the multi-disciplinary nature of primary care is a key feature of health strategies within all four nations of the UK. Despite this occupational therapy remains an underutilised and under researched area. This study has demonstrated the impact and importance of occupational therapy for patients receiving, and staff delivering primary care through delivering high levels of satisfaction and bringing a different expertise to the sector. To amplify the impact and value that the profession brings to primary care we make a number of recommendations to continue to develop the evidence base, increase knowledge of occupational therapy and address challenges the workforce faces. These are detailed in table 7 below.

The first set of recommendations relate to the need for increased evidence for occupational therapy in primary care. They focus on the need to create tools, agree metrics and support occupational therapists to use these tools and metrics for evidence collection to show impact.

The next set of recommendations focus on operational aspects of service delivery and the strong need to raise the profile of occupational therapy in primary care. Recommendations also drive at the need to tackle rural workforce challenges, pay at different levels of occupational therapy practice and the sustainability of lone working.

In total, if the recommendations are delivered, they would represent a substantial improvement in people's understanding of the power of what occupational therapists do both now and in the future transformation of primary care across the UK and internationally.

Table 6 Recommendations

| Challenge | Impact of this challenge | Recommendation | Who? |
|---|---|---|---|
| Standards of Evidence | | | |
| Difficulty evidencing the work OTs do in primary care | The preventative function of OTs work is invisible in primary care. | Create tool that will demonstrate prevention role of the profession in primary care.<br>Define how OT contributes to primary care prevention targets set in each nation. | RCOT |
| Variation in tools used by OT workforce to collect data | Non-standard information available on patient outcomes makes understanding population-level impact difficult | Adoption of widely agreed metrics to record patient progress and impact of OT. This may require the creation or adoption of a tool deemed fit for purpose for this use and should avoid detracting from the use of outcome measures as interactive tools for patient goal setting. | RCOT/wider practice in the occupational therapy community |
| Dual role of outcome assessments – both a tool to help patients, and a tool for tracking outcomes | Challenging to collect standardised data as current range of tools aren't comparable | | |
| Risk of data burden – if asking occupational therapists to collect | OTs may not be compliant with data collection due to time and effort involved | Educate around the importance and value of standardised data collection, and ensure outcome measures used as standard metrics are as simple as possible to administer | RCOT/wider practice in the occupational therapy community |

| | | | |
|---|---|---|---|
| more data to show impact | | | |
| Variation in IT skills of occupational therapist workforce | Varying quantity and quality of data records available in primary care mean it is difficult to make comparisons and understand the overall impact | Standardising systems of record keeping and offering training and support for using these systems to all staff. | RCOT/Wider practice in the occupational therapy community and working with wider primary care colleagues. |
| Operational | | | |
| Difficulty maintaining occupational therapist profile in GP surgeries | Decrease of referrals to OT and poorer patient journey and experience. | Ensure OT representation at key practice meetings (MDTs)<br>Desk space in practice for OTs<br>OTs to 'drop-in' to practices for informal time with practice colleagues<br>Support practices with campaign to understand how to use OT in primary care. | Occupational therapist based in GP surgery<br>RCOT |
| Lack of education in GP surgeries about role of occupational therapy and what to expect | Practices don't maximise use of occupational therapy service | Educate practices on the use and value of occupational therapists, and how to support them in practice. | Local system leaders |
| | | | |

| | | | |
|---|---|---|---|
| High turnover of GP surgery staff. | Burden on occupational therapist's time and resources to continually raise their own profile with colleagues. | Conduct awareness raising campaign:<br>1) delivered to practice staff about the occupational therapy offer<br>2) repeated regularly and to all new staff as part of the induction<br>3) Create prompts in patient consultations about how and when to refer to occupational therapy. For all staff conducting consultations. | RCOT<br>Practice Managers<br>IMT support |
| Hard to recruit to rural areas | Lack of occupational therapists applying for roles in rural areas | Campaign to raise awareness about the benefits of working in primary care and rural areas. | RCOT<br>Rural employers |
| Hard to recruit Band 6s | Lack of occupational therapists willing to take a band 6 position. | Increase to a band 7 posts<br>Reconsider skill mix for the profession in primary care. | RCOT<br>NHS Employers |
| Lone working means role requires confidence and experience. | Only suits certain cohort of occupational therapists. | Target recruitment at specific occupational therapist cohort | RCOT |
| Nature of lone working makes it difficult to develop and maintain occupational therapy networks | Occupational therapists may feel isolated and leave primary care | Provide occupational therapy related training opportunities. Occupational therapist support networks such as the RCOT Primary Care Occupational Therapy Network<br>Provide mechanisms so occupational therapists can remain connected with other local | RCOT<br>Local system leaders |

| | | | |
|---|---|---|---|
| | | occupational therapists in secondary and community care. | |
| Concerns that working in primary care will deskill occupational therapists. | Lack of occupational therapists applying for primary care roles. | Campaign to raise awareness about working in primary care as an occupational therapist. | RCOT |

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# Appendix 1 – Evaluation framework

## Evaluation framework

| Evaluation theme | Evaluation questions | Source of information | Collection method |
|---|---|---|---|
| Impact of OT for patients aged 65+ in primary healthcare | What existing evidence of their impact? | Published peer and grey literature | Rapid Evidence Review |
| | What outcome tools are used in the current evidence base? | | |
| | What are the most commonly presenting issues for older patients? | Primary care OT's<br>Local data | Survey<br>OT interviews |
| | What are the most commonly used interventions for older patients? | Primary care OT's<br>Local data | Survey<br>OT interviews |
| | What outcomes do patients experience as a result of OT in primary care? | Outcome measures (either current or to be implemented)<br>Patients | Local figures from the 5 sites<br>Case studies |
| | What is the patients' experience of care from OT? | Patients | Patient interviews<br>Case studies |
| | What would be the primary care alternatives if OT was not available? | Patients<br>GP's, Managers, other AHPs | Patient interviews and case studies<br>Interviews |
| | What are OT's perspective of outcomes for patients? | OT's | OT interviews<br>OT survey |
| Impact of OT for primary care services | How many patients do OTs see on average per month? | Primary Care OT's<br>Local figures from sites | Survey<br>Collated from existing appointment records |

| | | | |
|---|---|---|---|
| | How many GP surgeries do OTs cover and what is the total patient population size? | Primary Care OTs | Survey |
| | On average how many times will a patient be seen by an OT? | Primary Care OTs<br>Local figures from sites | Survey<br>Site data |
| | What is the average length of an OT appointment in primary care? | Primary Care OTs<br>Local figures from 3 sites | Survey<br>Site data |
| | How many patients to OT's refer on to other AHPS within primary care? | Primary Care OTs<br>Local figures from 3 sites | Survey<br>Site data |
| | How many patients do OTs refer to other health services outside of primary care? | Primary Care OTs<br>Local figures from 3 sites | Survey<br>Site data |
| | How many patients do OTs refer on to or back to GP's? | Primary Care OTs<br>Local figures from 3 sites | Survey<br>Site data |
| | What are other primary care workers experience of having an occupational therapist on site? What are the benefits and drawbacks of OT in primary care? What do they see as the impacts for patients? what do they envisage the consequences of not having an occupational therapist presence? | Other primary care staff | GP and Practice Manager interviews and other relevant roles |
| What are the experiences of OTs working in primary care? | What are the barriers and enablers OTs experience in working in primary care? | Primary Care OT's | Survey<br>OT interviews |
| | What are occupational therapists' experience of partnership working with other primary care colleagues? | Primary Care OT's | Survey<br>OT interviews |
| | What gaps do occupational therapists experience in being able to meet patient needs? | Primary Care OT's | Survey<br>OT interviews |
| | What are other primary care staff's experience of occupational therapy? | Other primary care staff | GP and Practice Manager interviews |

| | | | |
|---|---|---|---|
| Workforce | What are the workforce challenges that occupational therapists face in primary care? | Primary Care OT's | Survey<br>OT interviews |
| | What are the challenges primary care teams face in recruitment of occupational therapists? | Other primary care staff | GP and Practice Manager interviews |
| | What are the solutions found to these challenges? | Primary Care OTs and other primary care staff | Survey<br>OT interviews<br>GP and Practice Manager interviews |
| | How are occupational therapist supervision needs met | Primary Care OTs | Survey<br>OT interviews |

# Appendix 2 – Research tools

## Patient topic guide

Thank you for your time today. My name is _____ and I am from an independent consultancy organisation called Rocket Science. We have been passed your details by _____ because you agreed to take part in an evaluation of occupational therapy in primary care.

Just to quickly recap the conversation you had before you agreed to take part, the evaluation is to help us understand the impact that the occupational therapy is having for primary care patients. Any information you share with us will only be used for this purpose and will be used anonymously so you will not be identified in anyway.

It is important that you do not feel under any pressure to take part in this interview and know that you can end the interview at any time without explanation and this will not affect you being compensated for your time. You do not have to answer all the questions and if there are any you would prefer not to answer please just say.

Do you have any questions?
Are you happy for us to go ahead with the interview?

### Access to OT

1. How were you referred for occupational therapy? (eg GP, practice nurse, hospital, etc)

2. What was the illness or condition that you were referred to OT for?
    a. How long have you been experiencing this?
    b. Had you had other treatment for this beforehand?
        i. If yes what was this outcome of this for you?

3. Roughly how long were you waiting to see an OT?
4. How many times have you seen an OT about this illness or condition?
5. Have you ever received treatment from an OT before?
    a. If yes was this for the same condition or something different?
    b. What was the outcome of this for you?

## Experience of OT care

6. What type of intervention or care are you receiving from the OT at this time?
7. Overall, how would you describe your experience of care by your OT?

8. Have you seen any changes in your health since getting care from the OT?
    a. If so, what are these?

9. Have you experienced any changes to your mental health or wellbeing since accessing OT?
    a. If so, what are these?

10. Have you experienced any other wider or holistic changes to your life and lifestyle since receiving OT care?

    *Prompt for advice and outcomes around:*

    - *Lifting, moving, and handling*
    - *Prevention and staying active*
    - *Advice for carers/family members*
    - *Overall quality of life*
    - *Improved social activity/getting out*
    - *Family relationships*
    - *Other*

    a. What are these and what has been the impact?

11. Would you recommend OT for anyone in a similar situation to you?
    a. Why do you say this?

12. If you weren't able to see an OT what other type of care do you think you might be receiving?

13. Has the OT referred you on to any other healthcare service?
    a. If so, what are these (eg mental health services, physio, back to GP etc)

14. Is there anything else you would like to tell us about the care you have received from your OT?

Thank you again for your time and sharing your experience with us. Just to confirm everything you have told us today will be used anonymously and you will not be named or identified in the report we are preparing for the Royal College of Occupational Therapy. If at any time you would like to withdraw from the evaluation you can do so by contacting me or xxxxxxx who you first spoke to about the research.

In compensation for your time today we would like to offer you £25, we can provide you this as a gift card or a direct transfer into your bank account. Which would you prefer?

□ Gift Card

□ Electronic email address required:

□ Physical home address required:

□ Bank transfer

Account holder name:

Sort code (xx-xx-xx)

Account number

Would you like to be informed of the findings of this evaluation

□ Yes

□ No

## Primary care staff topic guide

Thank you for your time today. My name is _____ and I am from an independent consultancy organisation called Rocket Science. We have been commissioned by the Royal College of Occupational Therapists to carry out an evaluation of occupational therapy in primary care.

The evaluation is to help us understand the impact that occupational therapy is having for primary care patients. Any information you share with us will only be used for this purpose and will be used anonymously so you will not be identified in anyway.

It is important that you do not feel under any pressure to take part in this interview and know that you can end the interview at any time without explanation. You do not have to answer all

the questions and if there are any you would prefer not to answer please just say. I will not be recording this interview but will be taking notes. Is that alright with you? If we use any direct quotes from this interview they will be anonymised and will not be able to be traced back to an individual.

### Role within Primary Care

1. Can you please start by telling me about your role within Primary Care?
2. Approximately how long has your primary care service provided OT?
3. Are there any specific areas/specialities that OT provides in your Primary Care Service? (eg frailty, learning disabilities, mental health etc)
4. How well embedded do you feel OT is within your primary care service? *[prompt for how well do referral pathways work, are all staff aware of what OT does and can offer within the service etc]*
    a. What facilitates/hinders this?

### Experience of working with OT's

5. Overall, how would you describe the experience of providing Occupational Therapy within Primary Care?

6. What, if any, benefits or impacts are there to providing Occupational Therapy for…
    a. Patients
    b. Medical staff (GP's and nurses)
    c. Other Allied Healthcare Professionals (eg Physio, Speech, and Language etc)

7. What do you envisage might happen should Occupational Therapy no longer be available within primary care for…
    a. Patients
    b. Medical staff (GP's and nurses)
    c. Other Allied Healthcare Professionals (eg Physio, Speech, and Language etc)

8. Do you experience any challenges or drawbacks from providing OT from your primary care service? *[prompt for patients, medics, and other staff]*

9. [If applicable] how easy have you found it to recruit OTs to work within primary care?
    a. What are the challenges to recruitment

b. What works well for recruitment

10. Are you aware of any other challenges in relation to the OT workforce?

11. Is there anything else we should discuss in relation to the impact of OT in primary care?

# Occupational therapist survey questions

## The impact of occupational therapy in primary care in the UK- survey.

RCOT in partnership with Rocket Science are currently evaluating the impact of occupational therapy in primary care. This research funded by Health Education England aims to help us better understand the impacts that occupational therapists have for patients, the primary care team, and wider systems. This will be used to help us make workforce recommendations and promote the contribution you make.

As part of the evaluation, we are conducting a survey of occupational therapists who currently work in primary care/GP surgeries in the UK. It is divided into three sections which ask about:

Section A – Needs, interventions, and volume of your activity

Section B -Your views on the difference you make and outcome measures

Section C – Challenges and solutions to working in primary care

The survey should take about 30 minutes and completing it means you consent to take part.

For the questions about volume of your activity, you may need to check back in your records for average figures. We only need approximate figures. We will ask you for example, about numbers of referrals and discharges in a month; your caseload size; the number of times you see the same patient and the length of appointments. It may help to have this information to hand before you start the survey. All contributions will be used anonymously, and your data will be stored and protected securely in line with GDPR legislation.

If you have any queries, please email laura.mcginty@rocketsciencelab.co.uk or Genevieve.smyth@rcot.co.uk

### Section A –Needs, interventions, and volume of your activity

1. What country do you work in? (please choose one)

- ☐ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland

2. What is your job title in primary care?
   - ☐ Occupational Therapist
   - ☐ Mental Health Occupational Therapist
   - ☐ Other (please state)

3. How many GP surgeries do you work with? (free text number)

4. What are the most commonly presenting needs for patients you see in primary care? (Choose all that apply)
   - ☐ Aids/Adaptation assessment
   - ☐ Chronic Pain
   - ☐ Cognitive difficulties/function
   - ☐ Decreased functional ability
   - ☐ Developmental delays in children
   - ☐ Frailty
   - ☐ Home safety
   - ☐ Learning disabilities
   - ☐ Life-limiting illness
   - ☐ Mental health
   - ☐ MSK/rheumatology
   - ☐ Recovery from injury
   - ☐ Social Isolation
   - ☐ Workplace problem /environment assessment
   - ☐ Other

5. What occupational therapy interventions/support do you use the most frequently in primary care? (Choose all that apply)
   - ☐ Assessment for aids/adaptations
   - ☐ Carer advice
   - ☐ Decreasing social isolation
   - ☐ Grading/adapting activities
   - ☐ Increasing activity levels
   - ☐ Problem solving and goal setting
   - ☐ Provision of equipment/adaptions
   - ☐ Rehabilitation programs

- Return to work advice
- Self-help/self-management advice
- Signposting to other sources of support
- Other (please state)

6. On average how many new patients do you receive/take on in one month (Free text number)

7. If you carry a caseload, on average, how many people do you have in one month? (Free text number)

8. How many patients do you discharge, on average, in one month? (Free text number)

9. What types of appointment do you offer to primary care patients (choose all that apply)
    - Home visits
    - Care home visits
    - Face to face in GP surgery
    - Face to face somewhere else (please tell us where)
    - Virtual/telemedicine (eg Teams call or Zoom)
    - Telephone call
    - Other (please tell us what)

10. Approximately how many total patient interactions do you have in one month (include all types of appointments listed above).
    - 0-25
    - 26-50
    - 51-75
    - 76-100
    - 101-150
    - 150+

11. How long, on average, is a session with a primary care patient?
    - Less than 15 mins
    - 15-30 mins
    - 31 mins - 1 hour

- 1-2 hours
- 3+ hours

12. On average, how many appointments will a patient have with you prior to their discharge?
    - 1-3
    - 4-6
    - 7-9
    - 10+
    - other (free text)

13. On average, what percentage of patients you see need MORE for more than two appointments?
    - 0%-25%
    - 26%-50%
    - 51%-75%
    - 76%-100%

Section B -Your views on the difference you make and outcome measures

14. To what extent do you agree with the following statements.

| *Tool/measure* | *Strongly disagree* | *Disagree* | *Neither agree nor disagree* | *Agree* | *Strongly Agree* |
|---|---|---|---|---|---|
| Occupational therapy interventions in primary care have a positive impact on patients | | | | | |
| Please give examples (free text) | | | | | |
| Occupational therapy interventions improve outcomes for primary care patients | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Please give examples (free text) | | | | | |
| Occupational therapy interventions create efficiency or alleviate pressure in primary care (eg saving GP time) | | | | | |
| Please give examples (free text) | | | | | |
| Occupational therapy interventions reduce onward referrals to social care | | | | | |
| Please give examples (free text) | | | | | |
| Occupational therapy interventions reduce referral to secondary or tertiary care | | | | | |
| Please give examples (free text) | | | | | |

15. How often, if ever, do you refer patients to other members of the primary care team?

- ☐ Never [route to Q14]
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

13 a) Which services do you most commonly refer to (tick all the apply)

- ☐ GP
- ☐ Health and wellbeing coach
- ☐ Mental health nurse
- ☐ Another mental health practitioner (please state)
- ☐ Nurse
- ☐ Other AHP

- ☐ Pharmacy
- ☐ Physician associate
- ☐ Physiotherapist
- ☐ Social prescribing link worker

16. How often, if ever, do you refer patients to services outside of primary care?

- ☐ Never [route to Q15]
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

14a) which services outside of primary care do you commonly refer to (tick all that apply)

- ☐ Cancer Services
- ☐ Charities
- ☐ Clinical Psychologists,
- ☐ Community Nursing,
- ☐ Dietician
- ☐ Lymphoedema service
- ☐ Memory Service
- ☐ Mental health services
- ☐ Older adult community mental health team
- ☐ Orthotics
- ☐ Palliative Care,
- ☐ Paramedic,
- ☐ Physiotherapy, Radiology,
- ☐ Podiatrist
- ☐ Radiology
- ☐ Respiratory Therapists
- ☐ Rheumatology
- ☐ Social Prescriber,
- ☐ Speech and Language Therapy
- ☐ Other (free text)

17. Which if any, of the following outcome measures have you used in primary care, and how often have you used it?

| *Domain* | *Tool/measure* | *Never* | *Rarely* | *Sometimes* | *Often* | *Always* |
|---|---|---|---|---|---|---|
| Multi-domain (eg physical, mental, and social health) | Patient Reported Outcomes Measurement Information system (PROMIS) | | | | | |
| | Goal Attainment Scaling (GAS)/ GAS LITE | | | | | |
| | Therapy Outcome Measures (TOMs) | | | | | |
| | Australian Outcome Measure (Aus-TOMS) | | | | | |
| | Worker Role Inventory (WRI) | | | | | |
| | EuroQol -5D (EQ-5D) | | | | | |
| | Assessment of Work Performance (AWP) | | | | | |
| | Canadian Occupational Performance Measures (COPM) | | | | | |
| | Functional Autonomy Measurement System (SMAF) | | | | | |
| | Adult Social Care Outcomes Toolkit (ASCOT) | | | | | |
| | Primary Care Outcomes Questionnaire (P-COQ) | | | | | |
| Frailty | PRISMA-7 Questionnaire | | | | | |
| | Edmonton Frail Scale | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Clinical Frailty Scale | | | | | |
| | Electronic Frailty Index (eFI) | | | | | |
| | Gait (Walking) Speed Test | | | | | |
| | | | | | | |
| Motor/functional ability | Time Up and Go (TUG) Test | | | | | |
| | Assessment of Motor and Process Skills (AMPS) | | | | | |
| | Bristol Activities of Daily Living Scale | | | | | |
| | Allen Cognitive Level Screen (ACLS) | | | | | |
| | Barthel Index (BI) | | | | | |
| Environmental | Residential Environment Impact Scale (REIS) | | | | | |
| | Work Environmental Impact Scale (WEIS) | | | | | |
| Psychological health/wellbeing | General Self-Efficiency Scale (GSE) | | | | | |
| | Warwick Edinburgh Mental Wellbeing Scale (WMWEBS) | | | | | |
| | Generalised Anxiety Disorder Assessment (GAD-7) | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Patient Health Questionnaire 9 (PHQ-9) | | | | | |
| | Beck Depression Inventor (BDI) | | | | | |
| | Hospital Anxiety and Depression Scale (HADS) | | | | | |
| | Recovery Star | | | | | |
| Other | Readiness for Return-to-work Scale (RRTW) | | | | | |

*Other (please tell us which)*

## Section C – Challenges and solutions to working in primary care

18. Challenges to new professions working in primary care have been identified in the literature. Please indicate which if any of these you have experienced challenges with and how often:

| *Challenge* | *Never* | *Rarely* | *Some-times* | *Often* | *Always* |
|---|---|---|---|---|---|
| Clarity of purpose of your role as an occupational therapist | | | | | |
| Shared understanding of role of occupational therapy in the primary care team | | | | | |
| Capacity/readiness of other primary care services to support occupational therapy | | | | | |
| Readiness of primary care structures/pathways to support occupational therapy | | | | | |
| Recruitment and retention of occupational therapists | | | | | |
| Induction to working in primary care | | | | | |
| Supervision/Management support | | | | | |
| Peer support | | | | | |
| Access to training and development | | | | | |
| Opportunities for Career progression | | | | | |
| Manageable workload | | | | | |

19. How often, if ever, do you feel that you are able to find solutions to the challenges you face when working in primary care?

- ☐ Never [route to Q18]
- ☐ Rarely [route to Q18]
- ☐ Sometimes
- ☐ Often
- ☐ Always

*If they answered *'Sometimes,' 'Often,' or 'Always'* to Question 16 respondents will be directed to Question 16.a. 'Never' and 'Rarely' will proceed directly to Question 17

17.a. Please describe the solutions you found to the challenges you faced. [open *text]*

20. How often do you feel that you are able to meet the needs of the patient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often [route to Q19]
- ☐ Always [route to Q19]

18.a. Where are the gaps that make you unable to meet patient needs?

*[Open text]*

21. How would you rate your overall experience of working in partnership with other primary care colleagues?

- ☐ Very negative
- ☐ Negative
- ☐ Neutral
- ☐ Positive
- ☐ Very Positive

*a) why do you say this (free text)*

End of survey

Thank you for taking the time to complete the survey. Your responses will be used to help us understand the impact of occupational therapy in primary care and to inform future workforce planning. If you would like more information about the evaluation or would like to receive an update of the findings, please contact laura.mcginty@rocketsciencelab.co.uk

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