Allied Health Professional (AHP) Leadership in Local Authorities

Shining a light on leadership, impact and enablers to building health and social care collaborative partnerships and reform.

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NHS England and NHS Improvement

Contents

Foreword

This report shares a summary of findings and recommendations from a project which focuses on Allied Health Professional (AHP) Leadership in Local Authorities, commissioned by the Chief Allied Health Professionals Officer (CAHPO) for NHS England and NHS Improvement.

This project was initiated in response to:

1. **Feedback shared by AHPs in Local Authorities (LA) during the first AHP strategy development** in 2016. The AHPs into Action Strategy[1] published in 2017, provided a shared vision for how Allied Health Professionals (AHPs) can be utilised in transforming health, care and wellbeing. Feedback from LA AHPs during the crowdsourcing consultation for the strategy highlighted the need for more specific understanding of AHP leadership in LA.
2. **Requests by Occupational Therapists in Local Authorities, for national professional leadership, advice, and direction during the COVID-19 pandemic**, akin to their Social Work, Nursing and NHS AHP colleagues. Although not a new issue, this was particularly highlighted as absent, during the first wave of COVID-19 global pandemic.
3. **Commitment to optimise integration** and build stronger more integrated, collaborative partnerships across health and social care, to support and delivery of the ambitions of the NHS Long Term Plan[2].
4. **Collaborative discussions between the CAHPO at NHS England and NHS Improvement and the Chief Social Worker (DHSC)**, recognising the benefits diverse professional leadership can bring to the AHP and wider social care workforce including, effectively achieving good outcomes and experience for our population.

The professional leadership scoping and discovery work undertaken in this project, marks a significant and welcome opportunity to increase national visibility and strengthen the voice and professional leadership of AHPs, namely Occupational Therapists, within Local Authorities (LA's). It also provided an important opportunity for focus and development, that AHP leaders in Local Authorities have been seeking for many years.

Previous research conducted in Acute NHS Trusts, commissioned by the CAHPO office at NHS England/Improvement [3] has highlighted the benefits of professional leadership, including that:

1. **Diverse professional leadership** has a positive impact on outcomes and experience of our population receiving health and care services
2. **There is a correlation between senior AHP leadership and engagement of the AHP workforce**, including service, quality outcomes and performance.

This project summary aims to support health and care leaders to begin to understand what AHP professional leadership exists; what impact this has and how AHP leaders can be

[1] NHS England (2017) AHPs into Action - NHS England » About AHPs into Action Accessed 03.04.21
[2] Department of Health and Social Care (2019) **The NHS Long Term Plan.** https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf Accessed 23.03.21
[3] Harding D, Treadwell, L (2018) Allied Health Professions' Leadership in Acute Trust – what exists what matters Allied Health Professions' Leadership across the NHS in England (improvement.nhs.uk). Accessed 24.03.21

supported within Local Authorities, to optimise impact on population outcomes; workforce transformation and collaborative partnerships, key enablers to achieving health and social care reform.

Introduction

Allied Health Professionals (AHPs), collectively comprise of 14 professions, and are generally referred to as the third largest workforce in the NHS. However, AHPs are not only employed within the NHS, they work within wider sectors such as the independent sector; third sector and Local Authorities.

AHP leaders in LA's can….lead service change that has a positive impact on **workforce morale** and reduce the need for statutory services, through **early intervention**, embedding an **enabling mindset** and '**assistive technology first**' approach, that **focuses on the strengths** of individuals and carers.

Led by the Principal Occupational Therapist, Kirklees Council

The findings of this report are consistent with national statistics[4] in 2019/2020 confirming that, Occupational Therapists are the only Allied Health Profession, directly employed by Local Authorities. However, further research/development of evidence, would help to confirm this remains the case into 2021.

Within Local Authorities, there are three main regulated professions, in terms of workforce size, the above data source suggests that there are approximately 36,000 Nurses; 19,500 Social Workers and 3,500 Occupational Therapists.

Whilst Occupational Therapists are currently the smallest regulated profession within Local Authorities, Occupational Therapists are an essential part of LA workforce, working and leading in Health and Care services that support individuals with care and support needs, in line with The Care Act (2014)[5]. Occupational Therapists also support the delivery of the provision of housing adaptations under the Housing Grants, Construction and Regeneration Act 1996[6].

With the potential to be further utilised and invested in, AHP leaders in LA, support Occupational Therapists and wider social care teams, to bring an enabling mindset to their practice, helping individuals to achieve occupations (or activities) that the individual needs, wants or has to achieve in their everyday lives, delivering preventative services that efficiently deliver positive outcomes for our population, such as:

1. Optimising independence of individuals with complex needs
2. Helping people to remain in their own homes, rather than going into care
3. Releasing pressure from the care market by preventing, reducing and delaying the need for care and support.

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[4] Skills for Care (2019) workforce paper The state of the adult social care sector and workforce - The state of the adult social care sector and workforce 2020 (skillsforcare.org.uk) Accessed 24.03.21
[5] The care act (2014) Care Act 2014 (legislation.gov.uk)
[6] Gov.uk (1996) Housing Grants, Construction and Regeneration Act 1996 (legislation.gov.uk). Accessed 16.04.21

These preventative interventions which are strengths based and personalised to each individual, include interventions such as reablement, housing and environmental adaptations; use of technology enabled care and equipment solutions.

The main findings within this report were generated from regional AHP leader discovery workshops (ADASS/Principal OT networks) across England and wider networking opportunities and discussions with representatives from Department of Health and Social Care; NHS England/NHS Improvement; Royal College of Occupational Therapists; Skills for Care and Health Education England. For noting, whilst there were contributions from AHP leaders in LA children's services, the predominant contribution to findings came from AHP leaders within Adult services.

The following sections within this report will provide a summary of project including how AHP leadership can be nurtured and developed to optimise impact of Occupational Therapists in operational delivery and more widely, health and social care reform. Key recommendations will be made in order to develop this work further. Detail regarding the project objectives and methodology will be shared and key findings will be described. Risks associated with not taking timely action to continue to develop this work, will also be identified.

Summary

AHP leadership in Local Authorities' is active and present throughout England. AHP leadership in LAs, based on findings from this project is provided by Occupational Therapists, who are one of the three regulated professionals working in Local Authorities. Leadership roles providing AHP leadership such as Principal Occupational Therapists (POT), OT service managers and OT leads roles vary widely in relation to operational, strategic and professional leadership responsibilities; seniority and Local Authority understanding of what the role can deliver and the influence and impact it has.

This scoping exercise found that those in the most strategic roles, e.g. POT roles, working as peers alongside Principal Social Workers (PSW's) reported the most impactful leadership. AHP leaders identified key factors such as parity with PSWs and Assistant Directors in relation to seniority and visibility; opportunity for early collaboration on projects and service transformation and endorsement and support of the POT role from the Director Of Social Services and/or Head of Service, as key enablers to creating the optimal environment to impact on operational services and workforce at a strategic level.

The most impactful leaders were able to offer collaborative partnership and expertise utilising the breath of their Occupational Therapy knowledge and skills; whilst amplifying and driving preventative, personalised social care services that focus on enablement and independence.

Investment in leadership learning and development and means of evaluating impact of services is required to optimise AHP leadership in LA. This will assist in building confidence and capability of the Occupational Therapy workforce to lead and deliver effective service and workforce reform. Connection and collaboration with the AHP council and AHP Faculty, within Integrated Care System architecture and the newly established National AHP Care and Health Strategic Advisory Group provide opportunity for early collaboration and to build more collaborative relationships between health and social care system and clinical leaders, an essential foundation to achieving effective partnership working and integration within Integrated Care Systems.

Engagement with Directors of Social Services and Heads of Service, utilising the 'What exist, what matters' survey, is a vital next step which must occur in order to ensure our most senior

leaders in Local Authorities understand and amplify the impact their AHP workforce can have in relation to preventing, delaying and reducing the need for care and support, optimising the independence of our populations. Findings from this survey and appraisal of current workforce data will help to inform future collaborative action AHP Leaders can take across health and social care. In turn, this should assist in retaining, growing and recruiting the future AHP workforce required to deliver social care services at a more similar pace to the NHS.

In line with the other registered professionals in Social Care, national leadership to continue to drive workforce and service transformation will be vital. Findings from additional research, referenced above, are likely to provide further evidence to support the development of a publication, championing the role of Chief AHP/OT within the Department of Health and Social Care. This role would provide clinical and professional leadership to ministers and senior officers regarding AHP workforce and operational delivery in LAs that focused on enablement and prevention; increase visibility and optimise the effectiveness and impact AHPs can have on health and social care reform; influence national policy and provide high level professional advice, whilst working in partnership with the Social Care Chief Nurse, Chief Social Worker and Ministers.

Continuing to invest in and support the development of AHP leadership in LA, will ensure that the positive relationship that has now been forged between NHS England and Improvement, Department of Health and Social Care and LA Occupational Therapy leaders can continue to develop and grow, optimising the opportunity for integration and innovation at a person, system, regional and national level.

It is important to continue to move this important work forward, aligned with and at the same pace that NHS AHP leaders are being developed and supported, to negate a negative impact on performance and effectiveness of AHPs in LAs and prevent the increased risk of a reduced AHP workforce supply in LAs, particularly Occupational Therapists, who are a profession already on the UK's Shortage Occupations List[7]

As we work together to improve health and social care and increase the quality of services and outcomes for our population, in line with government policy[8] [9] there can no better time to continue to develop collaborative relationships between health and social care. Investing in AHP leadership in Local Authorities and understanding the impact it can have, will be vital to building strong clinical and professional relationships, within Integrated Care Systems.

Failure to take this forward, is likely to lead to a backward step in this important and developing partnership, essential to achieving new models of care and the wider health and social care reform required to deliver sustainable, quality health and social care services, that can meet the personalised needs of our diverse and increasing population.

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[7] Gov.uk (2021) Immigration Rules Appendix Shortage Occupation List - Immigration Rules - Guidance - GOV.UK (www.gov.uk) Accessed 21.04.21

[8] Department of Health and Social Care (2021) Integration and Innovation: working together to improve health and social care for all (publishing.service.gov.uk)

[9] Department of Health and Social Care (2019) **The NHS Long Term Plan.** https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf Accessed 23.03.21

Key recommendations

1.Continue to develop and build an inclusive support architecture for 2-way communication to build status of OT/AHPs in achieving integration, policy development, service, and workforce reform.

Invest in the newly established National AHP Care and Health Strategic Advisory Group, co-chaired by the Chief Social Worker (DHSC) and Chief AHP Officer (NHSE/I) to:

- **Utilise the collective knowledge of the health and social care group membership to influence, support and advise on strategies, policies and practice** aimed at bringing our health and care workstreams together, for the benefit of AHPs working across both health and social care.

- **To increase visibility and strengthen voice of AHP leaders in Local Authorities** and potential to collaborate and impact on workforce and social care reform. A further opportunity to increase visibility would be to share the impact of AHP leaders and the AHP/OT Therapy workforce with Ministers.

- **Increase consistent interpretation of the Principal OT role - Consider endorsement by CAHPO/Chief SW/Advisory group regarding, roles and responsibilities** document, created by the RCOT to support the consistency, understanding and impact of the Principal OT role in LAs.

2.Conduct further research to support the development and full utilisation of the AHP workforce in Local Authorities:

- **Leadership in social care survey** – what exists what matters – targeting Directors of Social services (DASS'S) or Heads of services, to be publicised via ADASS networks and newsletter. Distribution of the survey has been delayed due to the COVID-19 Pandemic.

- **Interview DASS's who have principal OTs** to evidence the impact/outcomes that having a principal OT has on service/population outcomes ink meeting statutory duties under the care act.

- **Utilise findings/themes from the AHP strategy development to inform and develop evidence based on citizen and AHP feedback.**

- **Develop citizen/person stories by interviewing citizens who have received services led by AHP leadership in LAs and develop person stories/case studies** to evidence the impact of this AHP leadership.

3.Investment in AHP leadership development, in Local Authorities

- **Investment in AHP leadership in LAs** is required to ensure all AHP leaders in LAs have the knowledge, skills, and confidence to share and develop the impact they have on services, including increasing integration and innovation opportunities.

- **Identifying requirements and commissioning/delivering** leadership training which is tailored to meet the leadership development needs. Including quality improvement, change management, project management methodology as well as compassionate and system leadership.

- **Offering or identifying provision to commission/signpost mentoring or facilitated peer support activities** such as action learning sets, would also help to develop and invest in the leadership development of this group.

- **Share the learning from Strategic AHP leaders** including what has empowered them to optimise impact in their roles.

- **Evaluate the impact** of leadership development/training/mentoring AHP leadership in Local Authorities

4.Scope and understand current and workforce future supply

- **Scope and understand LA AHP workforce -** statistics and requirements utilising the what exists what matters survey, to give a clearer picture of current workforce and requirements for future supply

- **Continue to seek and optimise opportunity for system collaboration** across health and social care in relation to workforce reform, by developing a plan/framework and recommendations based on findings.

5.Production of a publication, incorporating findings from this project and the above evidence and activity to support the development of a Chief AHP/OT in Department of Health and Social Care (DHSC)

Chief AHP/OT in DHSC with the aim to:

- **Provide clinical and professional leadership to ministers and senior officials on social care AHPs and the wider workforce and advise on operational delivery,** particularly in relation to preventative, enabling interventions/solutions that optimise individuals outcomes, reducing, delaying and preventing dependency on care and support; supporting people to remain in their own homes through environmental adaptation, equipment and technology and optimising integration and new models of care across the ICS architecture in relation to health, social care and housing.

- **Increase visibility and understanding of impact** the AHP workforce bring to LAs, strengthening their voice in influencing national policy.

- **Provide high-quality, professional advice** on longer-term priorities for social care and workforce reform.

A sector secondment within the Department of Health and Social Care in the first instance would support in developing and evidencing the value of this role working, alongside Chief Nurse and Chief Social Worker colleagues, in optimising Adult Social Care reform and workforce development.

Methodology

Over a five month period (Nov 2020 – March 2021) an AHP Clinical Fellow, working 18.5 hours per week, within the National Chief Allied Health Professionals Office at NHS England and NHS Improvement, was asked to lead a project to scope AHP leadership in Local Authorities.

At the beginning of the project, a driver diagram (**Appendix A**) was drafted which lay out the key areas that the project could explore, helping to provide focus and the development of a project initiation document and associated plan to deliver the project objectives.

AHP leaders in LA can….lead and develop services that help people to **remain in their own home**, through **enablement**, **environmental adaptation** (minor adaptations, disabled facilities grants to reduce the disabling impact of a home environment can have) as well as **equipment to aid daily living and advice and support**

Led by Principal Occupational Therapist, Nottinghamshire County Council

Objectives - The three main objectives and associated activities that were undertaken:

1. To develop an architecture and support network for AHP leaders working in Local Authorities

- Increased engagement with the **virtual platform** through promotion of Futures platform
- Increasing the number of AHP leaders on the Principal OT/Strategic **leader distribution list** held by the CAHPO Office.
- **Promotion of AHP council within AHP/ICS architecture**, connecting LA leaders to AHP council chairs.
- **Connected with regional principal OT networks** to understand existing architecture, allowing them to shape the project and support.

AHP leaders in LA’s can… **develop services** to optimise individuals’ outcomes using **technology enabled care, promoting independence, reducing dependency** on care

Led by Principal Occupational Therapist, Dorset

2. **To scope AHP leadership in Local authorities, making recommendation to develop and share examples of AHP leadership in local authorities.**

- **Carried out 7 regional Principal OT network discovery workshops,** to understand more about AHP leadership in Local Authorities, from the perspective of the AHP leaders.
- **Launched #Share2shine social media campaign** to 'shine a light on AHPs in Social Care', requesting people share impact examples of AHP and AHP leadership in social care. **(Appendix B and C)**
- **Connecting to scope AHP leadership; support architecture and existing AHP leadership support/offer -** Royal College of Occupational Therapists
- **Drafted AHP Leadership in LA electronic survey questions and uploaded to 'Citizen Space' - 'What exists, What Matters'** to gain LA organisational/Director of Social Services/Head of Service perspective on AHP leadership and its impact in LA. **Due to COVID-19 operational pressures, this survey was not launched, but is being finalised for approval with the insights team.**

3. **To collaborate with the Chief Social Worker and Chief AHP Officer to advise and support policy development, sharing the value that AHPs bring to local authorities.**

- **Carried out regular meetings** with Chief Social Worker for Department of Health and Social Care
- **Attended and presented at the National Chief Social Worker Q and A session,** which Principal OTs were also invited to attend
- **AHP Care and Health Strategic Advisory Group**
- Established the above advisory group, to be co-chaired by the CAHPO (NHSE/I) and Chief SW (DHSC)
- **Carried out national webinar with Chief AHP Officer (NHS England and NHS Improvement) and Chief SW (Department of Health and Social Care)** Sharing findings of AHP leadership in LAs with Principal OTs/OT Service Leaders.
- **Attendance at the NHSE/I Ageing Well clinical Cell –** providing a social care AHP professional/clinical perspective on policy development
- **Connecting to understand future workforce supply and leadership training investment –** connected with Health Education England, Skills for care

Key findings

Overall, findings from this project, have demonstrated that AHP leadership roles vary widely in Local Authorities. Here is a summary of the key findings:

Widely interpreted Occupational Therapy Leadership roles:

- **Professional AHP leadership roles** within Local Authorities were found to be entirely occupied by Occupational Therapists (OTs).

- **There is a wide variety of titles used for the most senior Occupational Therapy leadership roles in LAs** which include,– Principal Occupational Therapist; Occupational Therapy Service Manager/Lead; Occupational Therapy Lead or have a specific title associated to the service they led e.g. Assistive Technology Lead, with Principal OT title tagged on.

> AHP Strategic leaders in LA's can…. highlight the **issues and discrimination** experienced by people looking for accessible accommodation and bring together the housing providers to find county wide solutions.
>
> Led by Principal Occupational Therapist, Somerset County Council

- **Hybrid roles –** AHP leadership roles predominantly hold operational responsibility of a particular service(s) with add on duties of strategic OT professional leadership. Few strategic roles are solely strategic and tend to hold operational responsibility for a service e.g. Community Equipment service, Social Care reablement and others.

- **Time** - Operational pressures and responsibilities tend to dominate demand on time and leaders reported that this results in less focus on strategic, service and workforce development opportunities across wider social care services.

Seniority and line management of AHP leadership roles impact on influence, visibility and contribution of AHP leaders

- **Seniority of AHP leadership roles** – Whilst Principal Occupational Therapist roles reported to be predominantly positioned at a strategic level, these roles are few (approx. 35/155 across England, RCOT); AHP leadership roles are predominantly positioned at a Team Manger level and not found within the senior leadership team (SLT) in LAs. Those positioned in less senior roles consistently reported lack of visibility and opportunity to contribute. Those who are positioned within the SLT report that they have far greater influence and impact.

- **Line Management of AHP leaders** - Senior AHP leadership roles in LAs, are often line managed by Principal Social Workers or Assistant Directors. Principal OTs working at a strategic level, being line managed by their Head of Service or Director of Adult Social Services, working alongside Principal Social Workers and Assistant Directors, reported greater opportunity to be supported to positively influence, contribute and impact on social care services.

Sharing/evidencing impact of AHP leadership and services is variable, dependent on the seniority of the role.

From the impact examples shared by Leaders in LA's, these suggest (Appendix C) that:

- Strategic AHP leaders in Local Authorities, given the right conditions to thrive, have a positive impact on population, workforce, service, and financial outcomes.

- Strategic AHP leaders in LAs create opportunity for a new perspective and clinical/professional/citizen partnership working opportunity across health, social care, and housing at a local, service and system level.

- Strategic AHP leaders in LA offer opportunity for the development of new models of independence and support, by optimising prevention, integration, and innovation.

AHP leaders in LAs can…be a **system leader, connector** and **innovator** who optimises partnership working within an Integrated Care System, in relation to **workforce planning** and providing **professional social care perspective**, alongside nursing, social work and medical colleagues on policy/service/practice development to improve services that **optimise the health and wellbeing** of the population.

Led by Principal Occupational Therapist, Devon County Council

To note, the impact examples that were received were shared by strategic AHP leaders and supporting the theory that AHP leadership in LAs, given the right environment to thrive, can have a positive and significant impact on services/citizen outcomes and experience.

However, the absence of impact examples from less senior AHP leaders might suggest that more investment in creating the right environment and developing leadership knowledge, skills, and confidence of AHPs could help to increase visibility and impact.

"Occupational Therapy needs to position itself for the future and the focus on Leadership development is a critical component to success, not only for its profession but also for the citizens it serves" (Dessoye, 2021)[10]

[10] Dessoye, J (2021) **Effectiveness of Leadership programming in Developing authentic and transformational leadership skills in Occupational Therapists.** [Effectiveness of Leadership Programming in Developing Authentic and Transformational Leadership Skills in Occupational Therapists - ProQuest]() .*College of Saint Mary. ProQuest Dissertations Publishing, 28316283*. Accessed 23.03.21

AHP leaders explained the environment that helps to optimise leadership impact/outcomes in LAs:

Early collaboration:

AHP leaders in Local Authorities frequently felt they missed opportunities for collaboration and partnership working in relation to service transformation and quality improvement. Stating reasons such as lacking visibility or having been invited at a late stage once a project had already been commenced and designed. It was clear that in relation to organisation and system projects or initiatives, AHP leaders in LAs are keen to collaborate with health and social care colleagues as early as possible, to optimise opportunity for innovation and positive outcomes.

AHP leaders in LA's can….lead service change that has a positive impact on **workforce morale** and reduce the need for statutory services, through **early intervention**, embedding an **enabling mindset** and '**assistive technology first**' approach, that **focuses on the strengths** of individuals and carers.

Led by the Principal Occupational Therapist, Kirklees County Council

The established National AHP system architecture (Appendix D) of which its hubs are AHP councils, within each Integrated Care System, offer opportunity to build relationships, optimise collaboration, workforce and service reform, delivering outcomes based on population need. Whilst some Principal OTs/AHP leaders in LAs have already connected and are active members of their AHP councils' others were not aware of system level meetings or unable to attend meetings due to operational pressures. A missed opportunity for health and social care professional collaboration.

Continuing to connect health and social care AHP leaders at AHP Councils and AHP Faculties, should support the AHP workforce to strengthen their visibility, status, and impact together, across both health and social care.

Whilst collaboration and building relationships will be important to continue to develop quality person centred services and practice based on our populations needs, it will also be vital to prioritise focus on current and future workforce supply. Health and social care AHP Leaders, should collaborate wherever possible to recruit, retain and grow the future AHP supply, enabling LAs to keep pace with NHS workstreams, developments and opportunities such as preceptorship, return to practice, expansion of student placements and advanced practice. Further collaboration between HEE, Skills for Care and AHP leaders will help to achieve this.

It is vital in relation to workforce and service reform within each local health and care system, that AHPs leaders in the NHS understand that a win for AHP leaders in Local Authorities is a win for the NHS and vice versa.

Parity with Social Work and NHS AHP colleagues

Parity with colleagues across health and social care was a theme that arose across all the Regional Discovery Workshops. The parity that is sought is particularly in relation to both Principal Social Worker colleagues in LAs, as well as with Chief AHP colleagues in NHS organisations.

Whilst it is important to acknowledge that the Principal Occupational Therapist (POT) and the Principal Social Worker (PSW) are very different, yet complementary roles, in relation to the expertise, knowledge and perspective they bring, Principal OTs in strategic roles working alongside PSW colleagues, reported greater outcomes and impact when working as peers, benefitting from the development of an approach which embraces collaborative working, greater innovation and productivity, in relation to delivering on their workplans and LA priorities.

In developing parity with Principal Social Workers, much can be learned from the positive development of the Principal Social Worker role itself, now mandated within the Care Act with clearly defined roles and responsibilities[11] and employer standards for LA's employing Social Worker[12] that are monitored and developed on an annual basis through the Local Government Association (LGA) Health check survey. Henceforth, PSWs have benefitted from increased visibility, investment and a strengthened voice nationally, that has impacted positively on population, the social care workforce and LA outcomes.

Similarly, vital leadership and policy designed to support the development of Chief AHPs in NHS trusts[13], has provided resources and evidence to increase both the understanding of the impact the role of Chief AHP and the number of AHP roles at board level, across England.

AHP leaders in LAs can….
lead services that **increase individual and carer wellbeing** outcomes whilst demonstrating **cost savings** based on reduced care and support needs

'Getting People Home' Project
Led by Principal Occupational Therapist, Bristol County Council)

The Royal College of Occupational Therapists is currently developing a Principal OT roles and responsibilities document which will help to develop wider understanding and visibility within LAs, with the aim to provide a more consistent interpretation of the roles and

[11] Department of Health and Social Care (2019) SW roles and responsibilities document Role and responsibilities: adult principal social worker (PSW) (publishing.service.gov.uk) Accessed 24.03.21
[12] **LGA standards for employers of social workers -** The Standards for Employers of Social workers in England 2020 | Local Government Association Accessed 24.03.21
[13] CAHPO AHP leadership resources - Leadership of allied health professions in trusts: what exists and what matters | NHS Improvement Accessed 24.03.21

responsibilities as well as expected leadership outputs of the POT role, aligning with the RCOT career development framework[14] emphasising competency within the four pillars of practice – professional practice, facilitation of Learning, leadership and research and development.

Risks

Below are risks associated with not taking forward recommendations from this report:

- **Reputational impact**– NHSE/I have made a positive start in engaging with AHP leaders in LA, increasing support and visibility of their roles. LA AHP leaders started are anticipating that this work will continue to be carried forward and invested in. It this is not the case in may have a negative impact on NHSE/I reputationally.

- **Productivity and performance** in the AHP workforce in Local Authority not being optimised, due to lack of strategic AHP professional leadership.

- **Risk of reduced AHP workforce supply in social care** to meet the increasing requirements and needs of the population, due to lack of forward workforce planning and activities that support AHPs in LAs, in line with AHPs in NHS.

- **Integration -** Missed opportunity for building collaborative relationships and leadership across both health and social care towards stronger integration and innovation – optimising leadership in social care will support NHSE/I team to achieve/optimise LTP ambitions.

- **Social care and health reform –** AHPs in LAs continue to lack visibility in relation to the significant impact they could have on both health and social care reform, leading to continued focus on **care and support and crisis management rather than optimally investing in leadership that promotes independence**, enablement, and preventative interventions that keep people in their own homes.

[14] Royal College of Occupational Therapists (2021) Career Development Framework - RCOT Second Edition.

References:

1. NHS England (2017) AHPs into Action - NHS England » About AHPs into Action Accessed 03.04.21

2. Department of Health and Social Care (2019) The NHS Long Term Plan. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf Accessed 23.03.21

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10. Dessoye, J (2021) Effectiveness of Leadership programming in Developing authentic and transformational leadership skills in Occupational Therapists. Effectiveness of Leadership Programming in Developing Authentic and Transformational Leadership Skills in Occupational Therapists - ProQuest .*College of Saint Mary. ProQuest Dissertations Publishing, 28316283*. Accessed 23.03.21

11. Department of Health and Social Care (2019) SW roles and responsibilities document Role and responsibilities: adult principal social worker (PSW) (publishing.service.gov.uk) Accessed 24.03.21

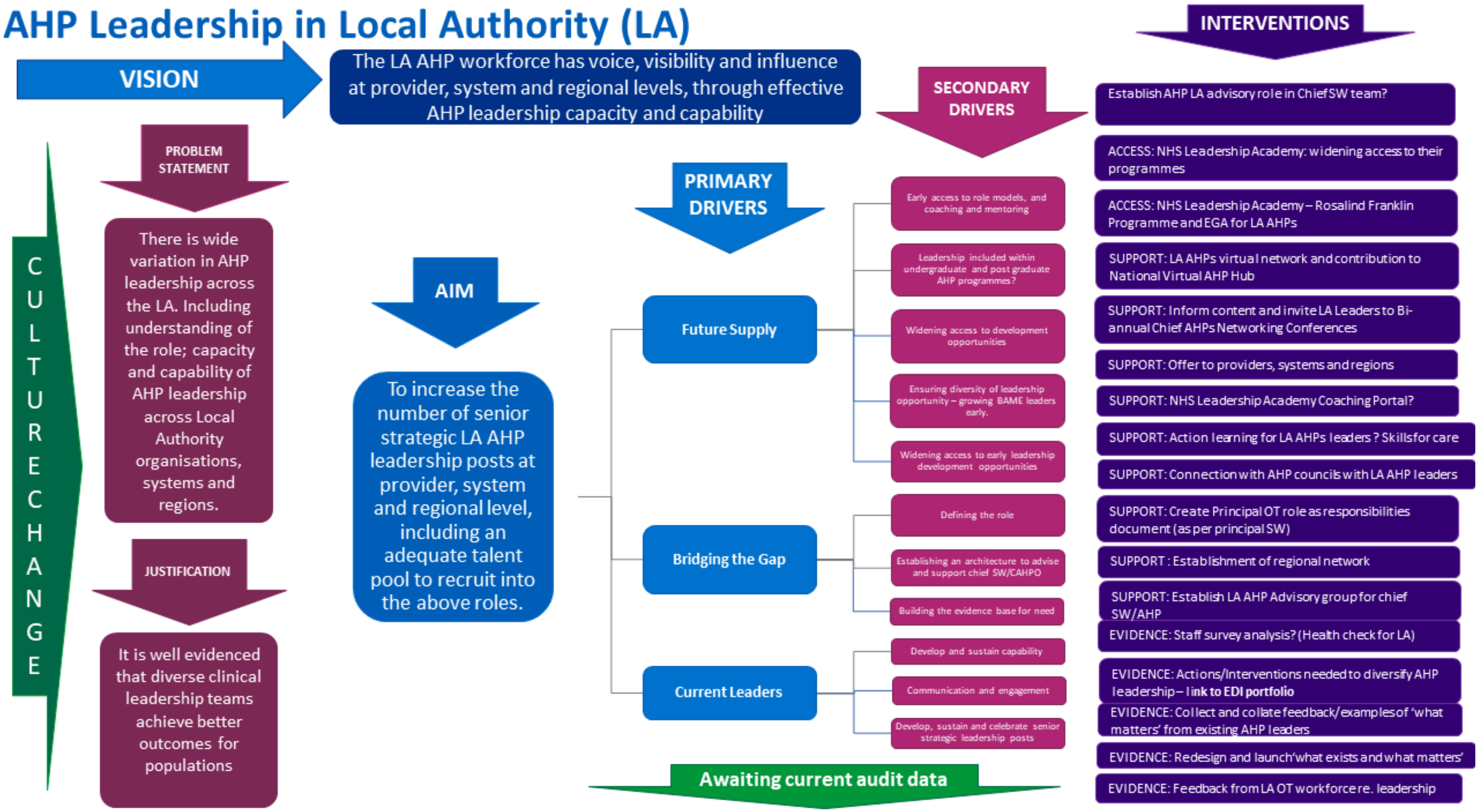
12. LGA standards for employers of social workers - The Standards for Employers of Social workers in England 2020 | Local Government Association Accessed 24.03.21

13. CAHPO AHP leadership resources - Leadership of allied health professions in trusts: what exists and what matters | NHS Improvement Accessed 24.03.21

14. Royal College of Occupational Therapists (2021) Career Development Framework - RCOT Second Edition.

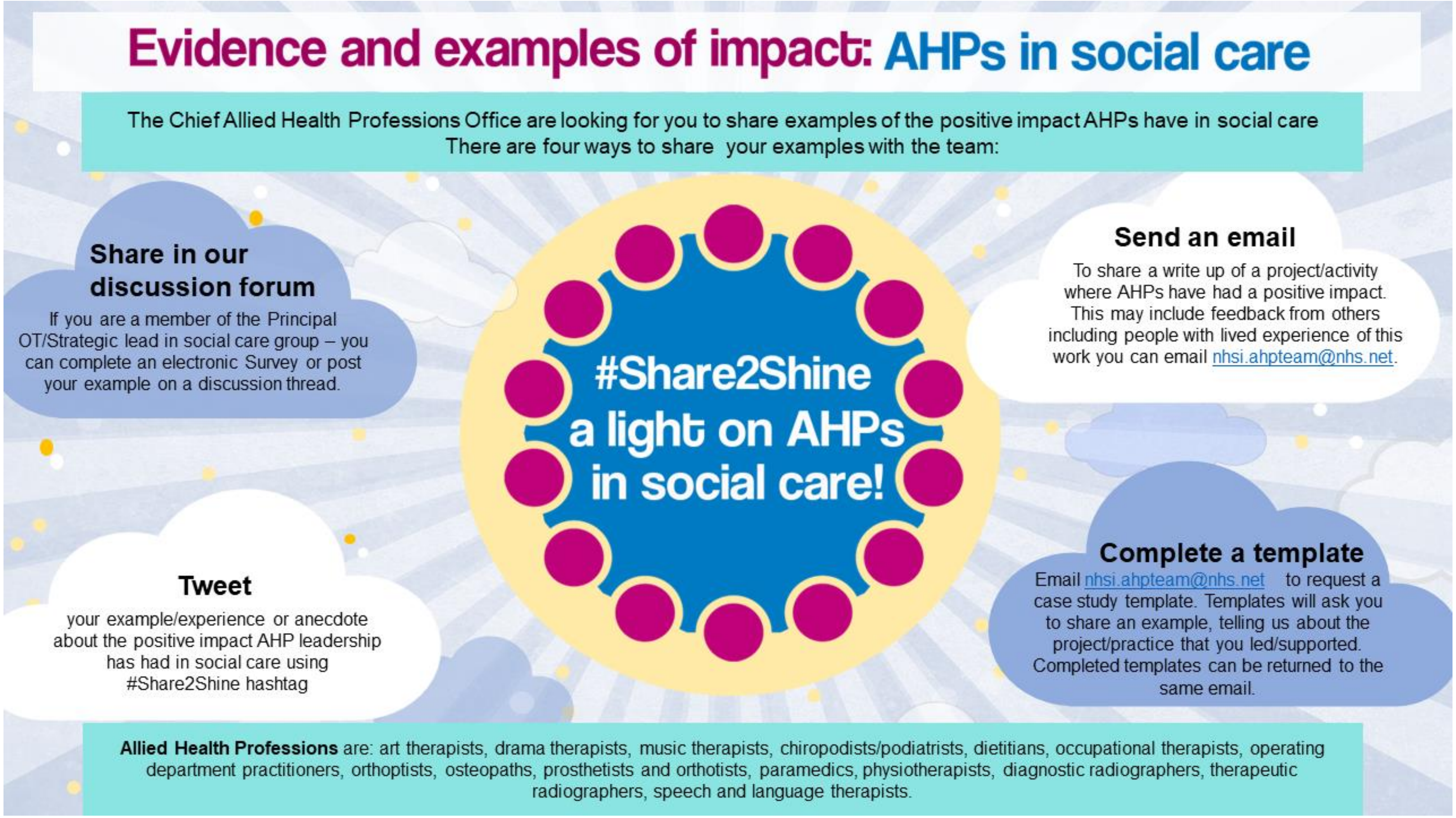
Appendices:

Appendix A: Driver diagram for AHPs in Local Authorities

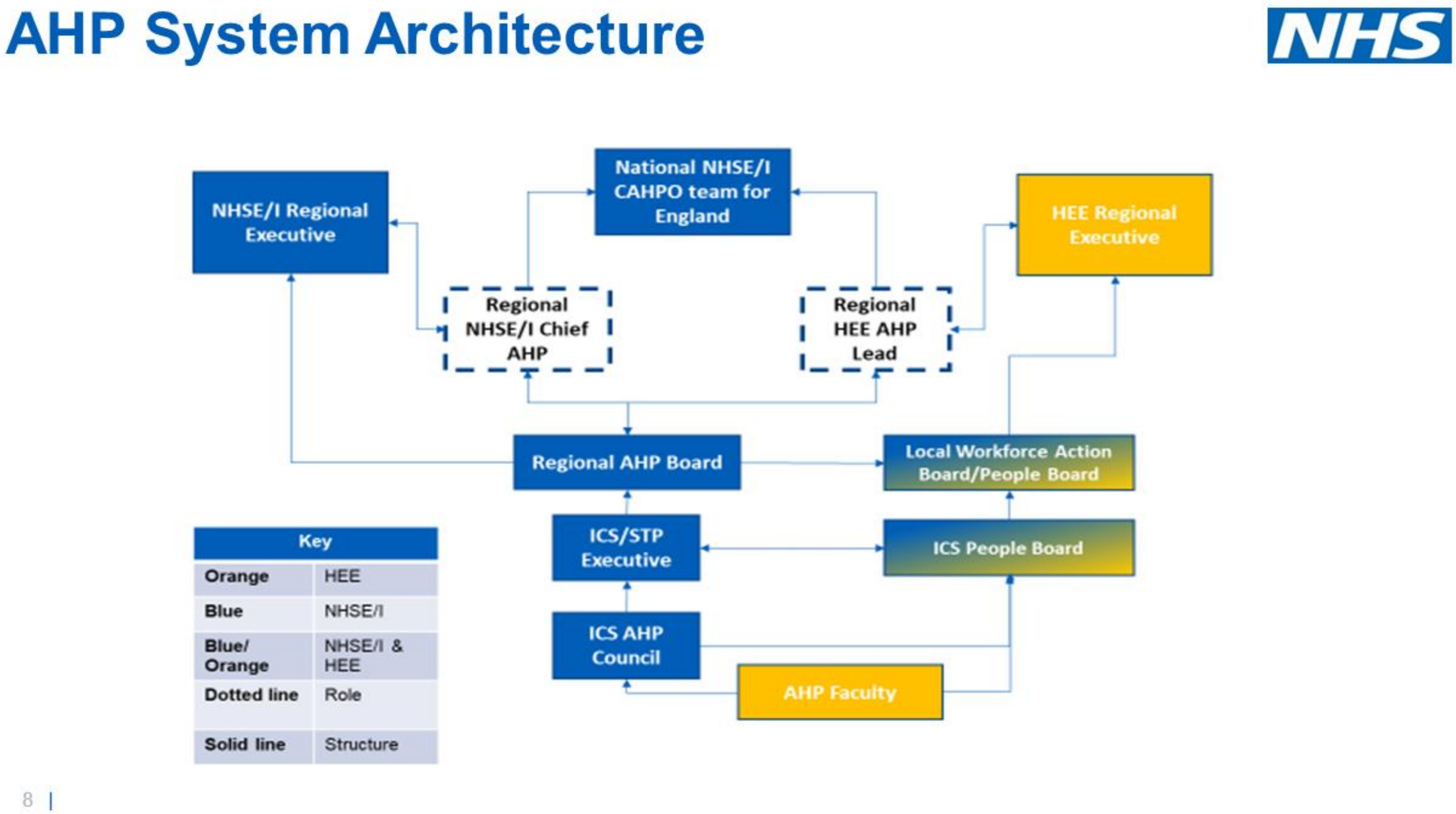


NHS England and NHS Improvement

Appendix B: Call for AHP Impact examples in Social Care social media campaign



Appendix C: National AHP System Architecture



AHP Leadership in social care: Demonstrating impact

What we need from you…whether you are an AHP leader in social care or someone who has benefit from AHP leadership…. please share with us an example(s) of a project or practice when AHP leadership in social care has had a positive impact.
Why we need this…this will help to demonstrate and showcase the impact and benefit that AHP leadership has in social care and allow us to share this more widely.

Name: Elke Small	**Email: elke.small@bristol.gov.uk**
Job title: Team Manager of the OT service	**Organization / Site: Bristol City Council**

Provide contact details – introduce the organisations and site:

Melanie Cooper: Melanie.cooper@bristol.gov.uk

Adult Social Care Bristol

What was the problem that required AHP leadership?

Evidencing the difference OTs can make in terms of cost savings in Adult Social Care

Aim and objectives (What was the project/leader hoping to achieve …)

Evidence that OT can make a difference to the cost of care packages by reducing the number of care calls and carers

Method and approach (How did you go about it/how was the project led…)

Presentation to Departmental Leadership Team about the evidence for the Getting People Home Project

Impact and outcome – What were the impact of the AHP leadership, what was achieved, were there any stats, a person story or quote you can share, to demonstrate the impact? We employed 3 Agency OTs who saved costs beyond their employment and equipment costs achieving a cost neutral outcome
Key learning points – for you and others In one of many attempts to demonstrate a real difference that OT can make to provision of care services we focused on cost savings as these are very tangible and when demonstrated clearly had an impact on Senior Managers. This has become a bit of a bargaining tool to identify the need for OT in other council services and particularly when new projects and services are set up We then added a case closure summary to our case notes which records the cost of intervention (equipment / minor adapts) and resulting care cost savings. Using this information, we continue to record monthly team direct and prevented (where a double up care package was prevented because of OT intervention) and predicted annual cost savings and showcase these on a regular basis. We also felt that to collect cost savings only; is not a true/ full reflection of the difference OTs can make; so we now also collect 'impact statements' from Service Users as to what difference the OT intervention has made and we can 'pull these off ' the system as and when we want to collect them .
Plans for spread. Do you have any plans for spread/ Is this something that could be replicated elsewhere? Things evolve all the time in relation to the positive impact that OTs can make, and this is only one of them but yes collecting actual and preventative costs has been an eye opener.

What we need from you…whether you are an AHP leader in social care or someone who has benefit from AHP leadership…. please share with us an example(s) of a project or practice when AHP leadership in social care has had a positive impact.
Why we need this…this will help to demonstrate and showcase the impact and benefit that AHP leadership has in social care and allow us to share this more widely.

Name: Cate Bennett	**Email: cate.bennett@nottscc.gov.uk**
Job title: Principal Occupational Therapist	**Organisation / Site: Nottinghamshire County Council**

Provide contact details – introduce the organisations and site:

Nottinghamshire CC Adult Care is a large 2 tier organisations with 7 district councils. The operational occupational therapy and community care officer (OT) are in each district Living Well and Ageing Well Team, alongside our social work and social care workers. Our Maximizing independence service is "therapy led" and covers all ages, it also has our direct care Reablelement Service which have dedicated occupational therapy.

What was the problem that required AHP leadership?

Delivery of Disabled Facilities across the county is different. There was no internal method of capturing information from when a person makes an enquiry or referral for adaptations (or re housing) to the outcome of their occupational therapy assessment of need and ongoing recommendation for major adaptations to the districts.

Aim and objectives (What was the project/leader hoping to achieve …)

To be able to gather timescale data from enquiry to OT recommendation of need
To be able to signpost people to DFG means test calculator
To understand the issues people, face during the DFG adaptation process
To promote the need for consistency across the District partners, based on postcode

Method and approach (How did you go about it/how was the project led…)

During an East Midlands Academy leadership course, a 100-day plan was developed to focus in on the objectives and establish outcomes achievable within a3 month period. - see attached. The Principal OT and Strategic Housing Commissioner worked together on developing this project, with POT taking a lead on the task and finish work.

Impact and outcome – What were the impact of the AHP leadership, what was achieved, were there any stats, a person story or quote you can share, to demonstrate the impact?

Due to Covid, time scales slipped and the whole project was at risk of being de prioritized at times. As Principal OT, I was able to keep the project on track by emphasizing the need to improve OT practice and improve experience for the people who use our services.

The stakeholder empathy mapping event (MS teams) was a key stage- it meant that people with experience of having an adaptation could share the breakout workshop sessions with OTs and grant officers, we "put ourselves in their shoes" and immersed ourselves in their experience. This resonated in a way that we still reflect on 6 months later. It was a method of unblocking organisational barriers and working in a strength-based way.

I didn't achieve all my outcomes in 100 days but have achieved some of my targets and other DFG service improvement opportunities have sprung up as a result.
Key learning points – for you and others **Use a template to map out your plan, aims objectives time scales and outcomes.** **Don't be disheartened when people don't think your project is important to the organisations, it might be next week!! It's all in the timing.** **Always be ready to give your simple key messages: the opportunity to influence can be a bit random!!**
Plans for spread. Do you have any plans for spread/ Is this something that could be replicated elsewhere? **This is one small part of a bigger whole. I find in my Principal OT role its best to take smaller steps to improve practice for my occupational therapy colleagues. There is so much to improve and there has been so little investment in OT in social care in the past.**

What we need from you…whether you are an AHP leader in social care or someone who has benefit from AHP leadership…. please share with us an example(s) of a project or practice when AHP leadership in social care has had a positive impact.
Why we need this…this will help to demonstrate and showcase the impact and benefit that AHP leadership has in social care and allow us to share this more widely.

Name: Dr Anita Mottram	**Email: anita.mottram@kirklees.gov.uk**
Job title: Principal Occupational Therapist	**Organisation / Site: Kirk lees Council – Social Care Occupational Therapists**

Provide contact details – introduce the organisations and site:

Kirk lees Council is a local authority based in West Yorkshire. This case study relates to work undertaken to embed the occupational therapy model into adult social care.

What was the problem that required AHP leadership?

Prior to 2017 there were no occupational therapists employed in adult social care, within the council and so we developed and funded a project to integrate them into our adult social care hubs. They would work alongside social workers and community assessment and support officers, contributing to social care assessments, undertaken under the legislative framework of the Care Act.

As well as acting as principal worker on those that benefitted from occupational therapy intervention, they would also support the work of their colleagues by providing functional interventions to better inform the outcomes of their assessments.

Unfortunately, the social care hubs had waiting lists, of varying length for Care Act assessments and so, what transpired, was that the occupational therapists were not allocated cases that would ensure a best use of their time and to produce better outcomes for the client, but were, instead, allocated ones that, often, were primarily social care focused, for example people who required intervention due to self-neglect, hoarding or safeguarding cases.

Staff started to feel demoralised, devalued and that they had lost their professional identity. There was a very high risk that we would not be able to retain them and that they would start to seek work elsewhere. The job was not considered to be an attractive one, by people external to the team, and this was reinforced by five attempts to recruit and no applicants applying for the posts.

The decision was made that this could not continue and so we took the decision to withdraw the occupational therapists from the hubs to develop a standalone therapy team.

Aim and objectives (What was the project/leader hoping to achieve …)

- The most important objective was to provide the occupational therapists with a role that was purposeful, where they could use their skills, more effectively, to meet client’s needs and was one that they felt valued their profession and themselves as individuals.

- Referrals would be received from any service, within the Council and the team would provide occupation-based interventions to enable clients to be maintained in their own home and to maximise their independence and prevent unnecessary hospital admission.
- By promoting meaningful occupation, through a range of solutions, the aim was that this would reduce reliance on more intrusive, statutory services.
- By supporting Gateway to Care, the "front door" of the council, referrals would be signposted more appropriately, and by providing early intervention and prevention this would reduce the number of referrals transferred to the social care hubs. The aim was that this would have an additional impact of increasing the capacity of the hub to work on more complex social care focused cases.
- The development of a separate referral pathway meant that it was possible to evidence the financial and qualitative implications of the occupational therapist's interventions.
- The occupational therapists were also encouraged to maintain close working relationships with the staff of the hubs and to be a source of knowledge and support for them, embedding an ethos of enabling and greater use of Assistive Technology solutions.

Method and approach (How did you go about it/how was the project led…)

The project was led by the Principal Occupational Therapist, but fully supported and championed by her Head of Service. Whilst the decision to change the role was made by these two, the evolution and operationalisation of the new role was undertaken in conjunction with the existing staff members who all provided a valued contribution to this.

As the occupational therapists were funded by monies from vacant social worker posts it was imperative that the benefits of changing their practice was shared with the hub team leaders, who were, in effect, losing social worker posts. We needed to reinforce that the occupational therapists would still contribute to the work of the hubs through continuing to support their hub colleagues with their assessments, but also by providing early intervention and prevention which reduced the number of referrals reaching the hubs, thereby increasing their capacity.

The remit of the new team was to use occupational interventions to enable people to regain control of their lives, promote independence and wellbeing and prevent potential deterioration in health and social care needs.

Once our intent became known then the Principal Occupational Therapist was contacted by a range of different services who could all recognise the benefit that access to occupational therapy intervention could have for their clients. This included the Blue Badge team, Gateway to Care, Assistive Technology services, the Wellness service, and Legal Services.

Rather than undertaking a lengthy consultation and redesign exercise, the change in practice commenced just four weeks after the initial decision was made for change. The occupational therapy staff are hugely experienced and very professional and very quickly implemented the new model.

This included developing and sharing criteria for referrals to the service and a new referral pathway which included adapting the existing client information recording system and developing codes to document interventions and outcomes. We were able to adapt the existing occupational therapy assessment tool so could continue to use this.

A start date was agreed and the changes in practice were communicated to other services within the council. We were aware that we needed to evidence the outcomes and interventions and so a referral spreadsheet was developed, by one of the team, to record this in an easily accessible format.

Impact, outcomes, and risk The impact of changing practice has proved to be far greater than anticipated. The perception of the role has changed and with it has come opportunities for improved recruitment. A recent advert led to applications received from five applicants, more than in the previous recruitment attempts put together! • The professional identity, morale and confidence of the occupational therapists has increased, and we have, thankfully, retained the staff who were already in post. • Rather than confining the therapy role to just adult social care, referrals have been received from several different services. This has included referrals from Legal Services, who have a identified the value of an occupational therapy assessment for some of their cases, an unanticipated outcome. • The occupational therapists are undertaking a different type of assessment to that previously undertaken in the hubs. They are more occupation focussed with an emphasis on maintaining and maximising independence. This is producing some very positive outcomes. The first three weeks of the changed role resulted in a saving of £58,600 through using alternative solutions such as assistive technology or change in technique to enable people, rather than providing a package of care. • The occupational therapists have more clarity as to the expectation of their role. • The capacity of the hubs has increased as the occupational therapists have prevented some referrals reaching the hubs by providing early intervention and prevention or signposting them elsewhere. • Clients are not having to wait as long for an assessment, as they did previously, preventing potential deterioration of situation. However, due to the increased number of referrals to the service, the waiting time, for occupational therapy intervention, has also increased, hence the need to recruit additional staff members. • The occupational therapists can provide flexible and creative interventions to a greater number of people and contribute to the models of home first and assistive technology first to reduce risk and promote independence. • The occupational therapists provide each other with peer support and regularly review and adapt how the service is working to make sure that it continues to operate at a high standard of practice. They also receive regular professional support from the Principal Occupational Therapist.
Key learning points – for you and others • To implement change does not have to be a long-drawn-out process and can be undertaken swiftly and effectively. • If something is not working, don’t be afraid to point this out and to stand up for what you believe in. • If your plans could be perceived to have a negative impact on others, make sure that you open lines of communication at an early stage to engage with them and to explain the potential benefits of what you are suggesting. • Occupational therapists are an amazing resource and crucial to the provision of high quality and effective social care solutions. We need more of them at the front line of social care to promote and maximize clients to be as independent as possible. • When you have a manager, who believes in you and trusts you to make the right decisions then this is a fantastic enabler for change.

Plans for spread. Do you have any plans for spread/ Is this something that could be replicated elsewhere?

- The change in role only took place three months ago but already the impact, that the team are having, is well recognized. As a result, we have just undergone a recruitment campaign which intends to double the number of occupational therapists in the team.
- The model of practice is not unique to Kirk lees and is already shared with neighboring colleagues, so that they may replicate it.

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Why we need this…this will help to demonstrate and showcase the impact and benefit that AHP leadership has in social care and allow us to share this more widely.

Name: Clare Lynch	**Email: Clare.Lynch@birmingham.gov.uk**
Job title: Occupational Therapist	**Organization / Site: Birmingham City Council (BCC).**

Provide contact details – introduce the organisations and site:

The Blue Badge Service, part of the Occupational Therapy department within Adults Social Care.

What was the problem that required AHP leadership?

Due to COVID-19 and the government announcement of the first national lockdown in March 2020, this led to the Blue Badge Service being unable to operate in its usual way of carrying out face to face mobility assessments as a result of the social distancing restrictions in place and the centers whereby the mobility assessments were previously held becoming closed to the public. Without any further action being taken this would have led to the assessments not being carried out and therefore Blue Badges across Birmingham not being provided to citizens in need, who require easier access to entrances to attend medical appointments, access essential medical treatment, complete essential shopping trips and to access their community safely.

Aim and objectives (What was the project/leader hoping to achieve …)

The aim was to enable the Blue Badge Service to still run as smoothly as possible by finding a safe and effective way for Occupational Therapists (OTs) within the Blue Badge Service to continue to carry out Blue Badge assessments despite the pandemic and for citizens with a physical disability who require a Blue Badge to still be awarded with a badge where required.

Method and approach (How did you go about it/how was the project led…)

Initially the decision was made for all face to face mobility assessments booked in for the following 3 weeks after the government's announcement of the national lockdown to be contacted to advise them their assessment would no longer be carried out at a CENTRE and would instead be carried out via a telephone assessment with an OT.

A plan was then put in place to change the assessment process and to include different questions within the assessment which may assist the OT to identify if an individual would be eligible for a Blue Badge without seeing the citizen face to face. Further support from myself was provided in the form of regular peer support catch up sessions with the Blue Badge Team, I carried out further training for Blue Badge staff, I put together a training

information pack for staff to refer to and ensured I was available to answer any staff's individual concerns or questions relating to specific assessments.
I set up an inbox which OTs could provide the email address for to citizens within telephone assessments whereby citizens had the option of sending in a short video of them mobilising at home which the OT could then review to identify the individual's mobility issues. The inbox was also used for citizens to send in any medical evidence from professionals within their care explaining their mobility issues and supporting the need for a Blue Badge.

Due to not all of the assessments carried out being possible to be approved via telephone, to avoid citizens being put onto a waiting list for a face to face assessment once there was guidance of the centers re-opening, several outside locations were considered to establish if there were any suitable for OTs to complete a mobility assessment outside with the citizen observing them mobilizing to determine the citizen's eligibility for the Blue Badge. A suitable outside venue at that time was not identified which would be deemed as a safe environment for citizens and staff, therefore it was decided to complete mobility assessments within an outside space from where the citizen resides such as along the road from their property – further training for staff was then put in place around the process and safety of this, PPE equipment was provided to staff with social distancing guidelines maintained and mobility equipment provided such as trundle wheels and stop watches for OTs to use within mobility assessments.

During the summer months my concern was once the weather became unsuitable and unsafe for citizens and staff to be completing assessments outside, there would not be an appropriate inside venue for these to be carried out. I therefore contacted over 50 venues within Birmingham to establish whether staff and citizens could use their indoor space once lockdown restrictions had been lifted to carry out mobility assessments. Following contacting many venues within Birmingham including libraries, sports halls, leisure centers, church halls and community centers, I was able to secure 2 venues in the North and South of Birmingham which citizens could travel to with the possibility of 2 further venues being used if required where the assessments could be carried out. A thorough risk assessment was carried out for both centers including a comprehensive COVID risk assessment to ensure both venues would be a safe environment for citizens and staff. Staff were provided with further training, further equipment including a thermometer to take each citizen's temperature upon arrival to ensure they did not have a high temperature which may have been a sign of COVID. Walking routes were then created and provided to staff to follow each route within the centers when carrying out the mobility assessments.

Impact and outcome – What were the impact of the AHP leadership, what was achieved, were there any stats, a person story or quote you can share, to demonstrate the impact?

The Blue Badge service was able to run as smoothly as possible within the challenging times of the pandemic, citizens across Birmingham with mobility issues were able to still be issued with Blue Badges where required. The venues secured offered a COVID safe environment for OTs to carry out BB assessments with citizens by ensuring social distancing was maintained, citizen's temperatures were checked upon arrival, a one way in/out system was adhered to, PPE was provided to all staff and citizens advised to wear face masks and to not attend the centers if experiencing any symptoms of COVID.

Due to successfully securing the new venues, over 150 citizens have been able to attend a face to face mobility assessment since September 2020 within a COVID secure CENTRE.

Individual story (verbal consent gained from citizen via telephone to share story): Miss S is 53 years old and suffers from severe spinal pain because of being involved in a car accident in 2011. As a combination of severe pain and breathlessness, Miss S's mobility is restricted whereby she is unable to mobilize very far and when attempting to complete shopping at her local supermarket reports this can take up to 3 hours due to the need to frequently take rest breaks to recover from the pain and breathing difficulties she experiences. Miss S attended one of the venues secured in the North of the city for carrying out mobility assessments and reports to have felt very safe in terms of COVID within the CENTRE she attended, she reports the OT who carried out her assessment was “brilliant and very understanding” towards her. Miss S reports the Blue Badge has been “a god send” enabling her to maintain her independence by being able to continue shopping for essential items for herself and her young children. Miss S reports her brother was unwell in hospital recently and she was able to use her badge to park closer to the entrance of the hospital which she recalls was a big help as without the badge she wouldn’t have been able to carry some essential items for her brother such as clothes to bring to the hospital due to having difficulty carrying bags over longer distances.

Key learning points – for you and others

This experience has increased my confidence in my ability to resolve issues and problems within challenging times when the solutions may not initially be clear. The experience has increased my professional skills such as problem solving, experience in liaising with other services, carrying out training sessions and ability of carrying out risk assessments.

As a team it has provided further experience to staff to complete assessments in different ways which going forwards will enable them to adapt their skills within other settings and situations. It has also enabled staff to use their clinical reasoning skills to identify individuals who require a Blue Badge by using different assessment methods and continue to provide a high level of service to citizens across Birmingham.

Plans for spread. Do you have any plans for spread/ Is this something that could be replicated elsewhere?

There are plans to develop more virtual assessments by exploring the possibility of carrying out video assessments which would reduce the amount of citizens requiring to travel to attend face to face mobility assessments and reduce the need of sending mobility videos via email.

There is scope for similar approaches and methods to be used across other services and departments to help tackle issues arisen from the effects of COVID-19 to different services.

Please send this form back to stephanie.gates@nhs.net
To contact the team about AHP leadership in social care, please email carolyne.hague1@nhs.net

AHP Leadership in social care: Demonstrating impact

What we need from you…whether you are an AHP leader in social care or someone who has benefit from AHP leadership…. please share with us an example(s) of a project or practice when AHP leadership in social care has had a positive impact.
Why we need this…this will help to demonstrate and showcase the impact and benefit that AHP leadership has in social care and allow us to share this more widely.

Name: Leane Shaw	**Email: leane.shaw@birmingham.gov.uk**
Job title: Wraparound service	**Organization / Site: Birmingham City Council**

Provide contact details – introduce the organisations and site:

Occupational Therapy service
Birmingham City Council
City wide

What was the problem that required AHP leadership?

The Wraparound Service is a therapy-led, non-commissioned service that began in December 2018 as part of a risk management strategy for winter pressures and DTOC. The service was so successful that after the completion of our interventions, as a reduction in the size of commissioned packages of care for service recipients over a period of time – the observed reductions over the period of April 2019 to March 2020 amounting to £1.8m non-cashable savings.
There is substantial evidence that citizens have a more rapid and fuller recovery at home as opposed to the alternative of temporary placements within care institutions.

Aim and objectives (What was the project/leader hoping to achieve …)

The objective of the Wraparound service is to support citizens with complex needs to be discharged home whilst maximising their safety and independence. Supporting citizens with more complex needs who fall outside of the remit of the Early Intervention Community Teams (EICT)EICT are assisted to return home rather than be placed into a short-term care placement.

Method and approach (How did you go about it/how was the project led…)

Key aspects of the service include ensuring clear communication with the hospital discharge team regarding safe discharge of the citizen and ensuring all the relevant equipment and documentation is in place to enable the discharge.

The service provides support for hospital discharges - with a home first ethos - for complex cases. All referrals are screened for the potential to eventually can reside within the community with minimal input from social care. However, upon discharge from hospital require more support than the traditional x4 care calls per day. Wrap Around had the flexibility of providing 24-hour care over the first 72 hours of discharge to support the citizen to settle at home and for organic routines to form.

Within the service a holistic view of the citizen is undertaken to enable co-ordinated access to the full range of therapy, care and support interventions that are available in the system. Typical interventions consist of therapeutic intervention and educating, simple equipment, minor adaptations, major adaptations such as stair lifts, ramps, wet rooms, ceiling track hoists, specialist equipment such as specialist in-situ chairs and shower chairs, Better care at home (BCAH),to reduce the care package from 2 to 1 carers when exploring manual handling needs for personalisation, physiotherapy interventions to support with balance, mobility, muscle strengthening, improving confidence and self-belief.

The team also work closely with housing services to support with rehousing, temporary accommodation and respite if needed. In addition, the team have access to Blue badge services.

Community assets are explored to ensure that all options are exhausted to provide the citizen with a greater sense of belonging within the community.

Citizens made it clear they wanted the opportunity to go home and try to remain within the community. Expressing they enjoyed, their privacy at home, having visits from friends, family especially grandchildren, when they wanted and voiced concerns this would change if they were to be placed into a formal placement.

Wrap around utilised technology enabled care and the assets of the community, e.g. citizens family/ friends, neighbours, and therapeutic interventions to supplement calls and grade down the amount of formal support.

WHO IS PART OF THE TEAM?

The Wraparound team consists of Occupational Therapists, Physiotherapists and social workers and carried out partnership working with Early Intervention, NHS community OT's and Physiotherapists, GP's, consultants, Mental health services such as Juniper, In-house Out of hours team, stroke team and Wheelchair services. The service works closely with the Hospital social worker and therapy team to ensure the discharges are streamlined and that all external services are in place (fracture review clinics and mental health appointments) and the case is transferred to the Hospital post-discharge social worker and on occasions team working with constituency colleagues.

WHAT TYPE OF PEOPLE DO WE SUPPORT?

Whilst it is not possible to describe a "typical case" some common features are signs of confusion/disorientation on admission but previously independent before with potential of returning to previous baseline. Citizens with fractures are another cohort that the service often supports; fractures usually take 6 weeks to heal and during this time rehabilitation therapy cannot commence with the potential for further deterioration and loss of independence.

For citizens with fractures, therapists within Wraparound complete an initial assessment within 24 hours of returning home (this is important to ascertain the need once discharged based on the assessed functional ability. A step up or down approach is taken to reflect the need and to allow proportionate levels of care) and then formulate a rehabilitation plan that is implemented once the fracture has healed.

The goals are set with the individual and are monitored periodically. Once the fracture has healed, to maximise the citizen's independence, resilience and reducing reliance on social care by utilising community assets and assistive technology.

WHAT ARE THE PROCESSES OF WRAPAROUND?

Once the referral has been accepted and the citizen has been discharged with the agreed level of care a visit is carried out by the Occupational Therapist within 24-hour to assess the needs and review the citizen within their home environment alongside goal setting. Then another assessment takes place within 72-hour. This joint visit with the Occupational Therapist and the Social worker to ascertain improvement in their presentation and to establish any risks identified. At this stage the team is more than likely to reduce the care packages as this has given the citizen time to adjust being at home. It was found at this time having accessible support the confidence of the citizen increased and they often advised the interventions to have supported them and they had settled into a routine and no longer required a high level of formal support. The citizen is at the heart of the service and the team works very closely with the citizen and family to understand how we reduce the care based on the recovery and needs identified.

However, if there was evidence that the citizen is not safe at home, evidence would be collated from the carers, therapists, social worker, assistive technology, and any external service, to support the citizen with provision of long-term placement. Assistive technology has been a massive asset to the service to ascertain the safety of the citizen between care calls and provides a non-invasive approach of sensors to monitor movements during the day/night to ensure they are maintaining their personal care needs, nutritional needs and general safety whilst at home. Therefore, some of the support provided would be a mixture of carers or could be monitoring systems.

Impact and outcome – What were the impact of the AHP leadership, what was achieved, were there any stats, a person story or quote you can share, to demonstrate the impact?

A reduction in the size of commissioned packages of care for service recipients over a period – the observed reductions over the period of April 2019 to March 2020 amounting to £1.8m non-cashable savings.

STORIES OF DIFFERENCES:

Ms A:

Ms A is an 18-year-old lady who suffered with her mental health resulting in jumping off a bridge and sustained multiple fracture.

Ms A was to be discharged to an older adult EAB. Following Wraparound screening it was clear that this would have been detrimental to Ms A mental health and ultimate recovery.

Ms A community assets were explored with the realisation that her only support was her mother who worked from 08:00 to 18:00 and could not support during this time. Ms A needed assistance of 1 for all activities of daily living and social care support was required. It was understood that there were no age appropriate rehabilitation convalescence facilities.

The social worker and Occupational Therapist completed a joint assessment to establish not only what goals were required for Ms A for her rehabilitation programme but also how many hours care she required to safely support during the day when her mother is not present.
As Ms A sustained multiple fractures, a thoracic brace was worn and fracture reviews were pending, therefore rehabilitation goals were minimal and main areas supported with, were identifying any simple equipment and minor works required which were a perching stool and toilet raiser for washing and toileting. Agreed to be downstairs living as stairs were not safe at present.   It was also identified that Physiotherapy were required, and the goal set was to get out of the bed every 3 hours for her wellbeing and to walk the length of the front room at least 2 laps at a time.
A week later the 2nd review took place and Ms B reached her goal with both bed and walking and we then increased the level of exercise with stair practice and accessing the upstairs facilities. Discussed possibility of reduction in care calls and decided that another week is required as Ms B felt that she still did not feel safe being home alone for any given period – this was agreed with the MDT.
3rd review took place 4 days later with completion of a walking frame caddy and OT commenced the leading role of light meal preparation once a week in the kitchen to regain confidence and to ensure safety as the carer is present. New goal was to access the facilities at least once a week.

A 4th home visit was completed and observed that Ms is now sitting upright on her bed without the aid of the profiling bed headrest. She is also sitting out in the dining room chair and at times walks to the bathroom without the aid of the Zimmer frame. She has an appointment with the fracture clinic for the wrist cast to be reviewed and possibly taken off. Occupational Therapist decided to contact Heartlands RAID team Conversation with Forward Thinking Birmingham and the Crisis Team (FTB Home Treatment Team). Ms B has been seen every other day since her discharge. OT liaised with the Crisis Team to ascertain progress. With liaison from the OT with the citizen her goals to continue studies were also explored and supported.
Care package was reviewed, and care was reduced from 12 hours per day to 2 hours a day with 1 carer twice a day for breakfast and lunch call to support with personal care and meal preparation.
Wraparound uses an MDT approach to support with a 7 weeks recovery programme with the end results of increased independence and ensuring the necessary services were in place to support with long term recovery, namely psychiatrist, medication reviews, therapist, and social worker support.

The impact
The original discharge pathway was for a 24-hour placement.   However, with Wraparound Ms A was discharged home with 11 hours care package. Following the final input, no care was required.

The outcome was that Ms A was fully independent and no longer reliant on any social care and had the motivation to complete her studies. Ms A reported that this was the first time she was fully heard and supported with all aspects of her life as she has attempted suicide on several previous occasions and no longer had this urge and she was thankful she was not required to go into a residential home, where she advised this would have brought down her morale and self-esteem.

Mrs B:

Mrs B, a 77 years old lady who previously was the main carer for her husband, suffered a stroke and resulted in multiple complications. Which meant she was not safe to go home with standard care package.

The original destination plan was for Mrs B to be discharged to a nursing home and ultimately her husband in a residential home which meant splitting the couple up.

The Wraparound service had extensive MDT meetings with the hospital to ascertain best course of action to ensure Ms B is discharged home safely. Once discharged home the Occupational Therapy and social worker completed their initial assessment and conclude that the appropriate package of care is one carer for 3 hours in the morning and then 4 hours in the afternoon with 2-night calls to support with personal care.

A 72-hour visit was carried out and the OT and SALT OT worked together to establish long term needs. It was agreed that Mrs B would require a long-term package of care with the goal to reduce to 4 calls a day with 2 carers.

It was also identified that the Occupational Therapist needed to source a specialised day chair with pressure relief, also observed the carers carry out safe transfers with a hoist and made a referral to the District nurses team for a tissue variability assessment to ascertain if the hospital mattress needs to be reviewed.

The following review it was agreed that Mrs B does not have appropriate adaptations to ensure she can safely bath as the bathroom was upstairs on the 1st floor and Mrs B could not manage the stairs. Birmingham City Council approved ground floor wet room adaptations to ensure the carers can safely bath Mrs B in the future.

In the interim the Physiotherapy services support Mrs B to strength her core strength and ability to extend the time she sits out in her day chair during the care calls. By the 8th week, core strength was maintained, sitting out between standard care calls were safe and general well-being and motivation had increased because Mrs B could not only see the progression, she has made but she was home with her husband and family. The care package was reduced to 4 calls a day with 2 carers to support with all activities of daily living.

The impact
The Wraparound service collaborated with the hospital discharge team to ensure Jill returned home with 24-hour package of care to meet her needs. Various external services together with members of the Wraparound team supported Jill and her husband at home and Mrs B made an impressive recovery of 4 calls a day collectively.

Wraparound intervention meant that that the couple could remain home with one care package to support both Mrs B and her husband's needs and they were able to remain together as this was both of their goal. As with out the initial intense amounts of care support she would not have been able to remain in the community within a familiar environment.

Key learning points – for you and others It was evident that certain cliental required additional time to recover and more intense rehabilitation and that they would successfully reach their mini and overall goal within their home at a faster rate. As they are not only more familiar with their home physically but mentally more at ease and comfortable. This helps the therapist and social worker to pain a real picture of not only their pace of recovery but essentially if they will be safe to remain home. Additionally, the joint working between Birmingham City Council and hospitals were a great success and filled any gaps and instead provided a seamless journey for our customers.
Plans for spread. Do you have any plans for spread/ Is this something that could be replicated elsewhere? This service was so successful that EICT has supported city wide with similar ethos and to ensure that the citizen is supported as soon as they are home and in their home environment.