



**CENTRE
FOR
WORKFORCE
INTELLIGENCE**

WORKFORCE RISKS AND OPPORTUNITIES

OCCUPATIONAL THERAPISTS

EDUCATION COMMISSIONING RISKS SUMMARY FROM 2012

AUGUST 2012

Welcome to the 2012 CfWI workforce risks and opportunities: education commissioning risks summary (WRO ECRS 2012) for occupational therapists.

The WRO ECRS 2012 reports cover all professions across health and social care, except the medical profession, which was covered in a report in 2011 (<http://www.cfwl.org.uk/publications/medical-shape-2011>). Each report describes the key issues facing the different professions over the next three years, and aims to support local decisions on future education and training commissioning. The reports do not make specific recommendations for local commissioning decisions as these decisions are made through consultation between the education and training commissioner and employers.

The reports will be submitted to the Department of Health in several tranches between November 2011 and the end of August 2012.

This is a time of great change in the NHS. Employers are considering how best they can transform their services to maximise the quality of patient care, improve productivity and release the £20 billion savings to be reinvested in front line clinical care. This work could have a major impact on the future shape of the workforce and so needs to be considered alongside education and training commissioning decisions that are being made now.

Financial allocations are a pivotal component of the overall education and training annual process across England. Presently, the Department of Health secures funding to invest in the workforce through the Multi-Professional Education and Training (MPET) levy, which is around £4.9bn for 2011/12. This funding is currently allocated to Strategic Health Authorities (SHAs) largely based on historical patterns of training. The Department sets out key priorities and holds SHAs to account through a Service Level Agreement. SHAs develop plans for education commissions based on local workforce plans and then commission and fund training from education and clinical placement providers.

Looking towards 2012/13, a 'flat cash' settlement for MPET is likely. This allocation will have to accommodate a range of cost pressures which will include new costs, price increases and volume changes. In setting local investment priorities for the MPET allocation, SHAs are encouraged to consider the evidence presented within the WRO ECRS 2012 and the medical specialty training numbers reports.

We hope you find the reports useful, and as always, appreciate your constructive feedback.



Professor Moira Livingston
Commissioning Director
CfWI

Purpose

This information has been collated to inform decisions on education commissioning over the next three to five years. It considers the key factors influencing the estimation of future need of the occupational therapy workforce, and gives an assessment of the current workforce supply. It includes regional perspectives and a summary analysis of risks in education commissioning.

Occupational therapists (OTs) assess, rehabilitate and treat people using purposeful activity and occupation to prevent disability and promote health and independent function. Occupational therapy is an NHS funded pre-registration course and students awarded an NHS funded place are also eligible for basic NHS bursaries.

KEY FINDINGS

- Supply forecast estimates for OTs marginally exceed demand according to CfWI modelling.
- Increasing demand for the services provided by OTs is likely to result from:
 - the ageing population
 - the increasing longevity of people with long-term conditions and complex needs
 - the potential rise in mental health conditions.

Further demand may also result from policy initiatives such as the drive for rehabilitation and reablement.

- The majority of SHAs report that the OT workforce is in a position of balance or slight oversupply. Oversupply is being managed through the use of talent pools for newly qualified practitioners and a number of SHAs are slightly reducing OT commissions.
- There are retention issues in the OT workforce across both health and social care. Rehabilitation needs to occur far earlier in the pathway for people who use OT services, ideally following the acute phase of care, with clear outcomes data collected on services.

Next steps

- SHAs to consider in-depth analysis of trends related to their workforce to better understand the current OT workforce and should keep their OT commissions under review.
- SHAs and local authorities to work together to understand the retention issues evidenced across health and social care.
- SHAs to promote talent pools more widely to support newly qualified OTs in finding their first posts. Training opportunities could be provided for those in talent pools to ensure their skills are kept up to date.

- Allied health professionals (AHPs) and commissioners to work together to ensure that coordinated rehabilitation takes place earlier in the pathway for people who use OT services, ideally following the acute phase of care, with clear outcomes data collected on services.
- Education training commissioners and workforce planners need to consider the demand for OTs in non-NHS sectors, such as social care, voluntary services and the private sector.

CONSIDERATIONS FOR FUTURE REQUIREMENTS

Policy drivers

Table 1 summarises the key policy drivers and the relevant references.

Table 1: Policy drivers affecting the workforce – occupational therapists

Key drivers	Relevant policy
<p>1. Integrating health and social care</p> <p>The Government has made a clear commitment to the integration of health and social care, initiated through the proposed reforms of the NHS and adult social care.</p> <p>As a profession with a significant presence across both health and social care, and with a significant role to play in preventing unnecessary admissions and readmissions, and supporting early discharge, the OT workforce is likely to be affected by the move towards more joined-up services.</p>	<p><i>Spending Review</i> (Chancellor of the Exchequer, 2010)</p> <p><i>A Vision for Adult Social Care: Capable Communities and Active Citizens</i> (DH,2010a)</p> <p><i>Equity and Excellence: Liberating the NHS</i> (DH, 2010b)</p> <p><i>The operating Framework for the NHS in England 2012/13</i> (DH, 2011a)</p> <p><i>Integration – A report from the NHS future forum</i> (DH 2012)</p>
<p>2. Drive for more personalised, preventive services focused on delivering the best outcomes</p> <p>Several policies have put forward the argument for more personalised, preventive care, where people have greater choice and control to meet health and care needs. OTs could have significant contributions to make in this area, through the promotion of self care, by engaging in a person-centred approach to assessment, interventions and reviews; and ultimately enabling people to live as independently as possible.</p> <p>To provide personalised care, services will shift from resource-led provision towards one where both the people who use services and their carers are empowered to make choices. To achieve this, the workforce will be required to</p>	<p><i>Nationally transferable roles (Skills for health, 2010)</i></p> <p><i>Healthy Lives, Healthy People: Our strategy for public health in England</i> (DH,2010c)</p> <p><i>A Vision for Adult Social Care: Capable Communities and Active Citizens</i> (DH,2010a)</p> <p><i>Equity and Excellence: Liberating the NHS</i> (DH, 2010b)</p> <p><i>Liberating the NHS: Greater Choice and Control</i> (DH,2010d)</p> <p><i>The operating Framework for the NHS in England 2012/13</i> (DH, 2011a)</p> <p><i>Implementing the Next Stage Review visions:</i></p>

work flexibly.	<i>the quality and productivity challenge</i> (DH, 2009a)
<p>3. Occupational health of the working population and vocational rehabilitation</p> <p>Policies may increase demand on OTs due to their specialist skills in supporting people to access, remain in, and return to work. These policies include:</p> <ul style="list-style-type: none"> • bringing occupational health services into mainstream healthcare • shifting perceptions towards prevention and health promotion • supporting vocational rehabilitation to improve the health of those out of work, and support people getting back into and staying in work. 	<p><i>Working for a healthier tomorrow – Dame Carol Black’s Review of the Health of Britain’s working age population</i> (Black, 2008)</p> <p><i>Improving health and work: changing lives</i> (DWP and DH, 2008)</p> <p><i>Working our way to a better mental health: a framework for action</i> (DWP, 2009)</p> <p><i>NHS Health and Well-being – Final report</i> (Boorman, 2009)</p> <p><i>Regional Trauma Networks for Major Trauma – NHS Clinical Advisory Groups Report</i> (NHS Clinical Advisory Group on Regional Trauma Networks, 2010)</p> <p><i>Universal Credit: welfare that works</i> (DWP, 2010a)</p> <p><i>Welfare Reform Bill</i> (Parliament UK, 2011)</p>
<p>4. Reablement¹</p> <p>The Department of Health (DH) has made approximately £232 million available to support reablement, which will be allocated to primary care trusts (PCTs), of which a large proportion will be transferred to local authorities (LAs). PCTs will work closely with trusts, LAs and community health services to develop local reablement plans. Part of this funding will be used to support the long-term investment in OTs, who are considered vital to reablement services. There will be a further provision of £300 million by 2014-15 to support continued investment in reablement services.</p>	<p><i>A Vision for Adult Social Care: Capable Communities and Active Citizens</i> (DH, 2010a)</p> <p><i>DH Press Release - £70 million support to help people in their homes after illness or injury</i> (DH, 2010e)</p> <p><i>DH press release - Extra money to help people leave hospital</i> (DH, 2011b)</p>
<p>5. Development of the appropriate skills to understand and meet the individual needs of people with learning disabilities and mental health problems</p> <p>The Mental Health Act (2007) led to opportunities for OTs to work as the responsible clinician (RC) and approved mental health practitioner (AMHP), due to their core skills in assessment, planning, intervention, evaluation and occupational performance.</p> <p>The launch of the Improving Access to Psychological Therapies (IAPT) programme also provided opportunities for OTs as low- and high-intensity cognitive behavioural therapy (CBT) workers. <i>Talking therapies: a four year plan of action</i></p>	<p><i>Valuing People</i> (DH, 2001)</p> <p>Disability Discrimination Act (2005)</p> <p>Mental Capacity Act (2005)</p> <p>Mental Health Act (2007)</p> <p><i>Improving Access to Psychological Therapies Implementation Plan: National guidelines for regional delivery</i> (DH, 2008a)</p> <p>The Autism Act (2009)</p> <p><i>New Horizons: A Shared Vision for Mental Health</i> (HMG, 2009)</p>

¹ Reablement refers to the process of rehabilitation in the social environment.

<p>outlines expansion plans for psychological therapies from April 2011 to April 2015.</p> <p>The continued expansion of IAPT, in conjunction with policies such as <i>Valuing People Now, Fulfilling and rewarding lives</i> and <i>No health without mental health</i> has led to an increased drive to support people with mental health and learning disability needs. This is likely to increase the demand on the OT workforce.</p>	<p><i>Living well with dementia: A National Dementia Strategy</i> (DH, 2009b)</p> <p><i>Valuing People Now</i> (DH, 2009c)</p> <p><i>Valuing People Now: The Delivery Plan 2010-11</i> (DH, 2010f)</p> <p><i>Fulfilling and rewarding lives</i> (DH, 2010g)</p> <p><i>Towards "Fulfilling and rewarding lives"</i> (DH, 2010h)</p> <p><i>Talking therapies: a four year plan of action</i> (DH, 2011c)</p> <p><i>No health without mental health</i> (HMG & DH, 2011)</p>
<p>6. Clinical leadership to meet future challenges</p> <p>Strong clinical leadership is needed to allow OT leaders to drive innovation and respond creatively and flexibly to the future. The aim is to build leadership awareness and capability by embedding the necessary competences in education and training. This could be taken into consideration by commissioners to meet the future needs of the service.</p>	<p>Modernising Allied Health Professionals Careers: A Competence Based Career Framework (DH, 2008d)</p> <p><i>Clinical Leadership Competency Framework Project</i> (NLC, 2011)</p>
<p>7. Preceptorship</p> <p>Preceptorship can be defined as a period of structured, supported training for newly registered practitioners, which aims to enhance their confidence and competencies. The preceptorship programme for OTs was designed as a supportive learning strategy to facilitate the transition of new staff into practice.</p> <p>The aim of preceptorship is to add value to the system by providing a foundation period for newly qualified practitioners at the start of their careers and supporting them in their journey from novice to expert. This should ensure practitioners are well equipped to meet the changing requirements of future healthcare provision.</p> <p>While the potential benefits of preceptorship to service users, employers and newly registered practitioners are clear, it will require an upfront investment of resource, as experienced OTs will be required to act as preceptors to support the preceptees.</p>	<p><i>Preceptorship handbook for occupational therapists</i> (Morley, 2009)</p> <p><i>Preceptorship framework for newly registered nurses, midwives and allied health professionals</i> (DH, 2010j)</p>
<p>8. Stroke</p> <p>The changes required to provide improved stroke services as outlined in the <i>National Stroke Strategy</i> resulted in an increased demand for the imaging and rehabilitation workforce, and the strategy acknowledges the important</p>	<p><i>National Stroke Strategy</i> (DH, 2007)</p>

role that OTs play in rehabilitation. The strategy further states that early supportive discharge to a comprehensive stroke specialist and multidisciplinary team in the community can reduce long-term mortality admissions into care and lower overall costs. According to Health Episode Statistics (HES) primary diagnosis figures, the number of admissions for stroke rose from 84,106 for 2006-2007 to 94,700 for 2010-11; and the number of bed days reduced from 2,192,010 to 1,967,854, which would indicate an increased level of demand on the OT workforce involved in rehabilitation of people following a stroke.	
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Strategic health authority (SHA) perspective

SHAs work in partnership with employers (service providers), service commissioners, education providers and each other to assess workforce requirements. This then informs education commissioning plans in each region. SHAs work with local employers to inform their decision making. This is a requirement of service level agreements between SHAs and the Department of Health for the investment of education and training funds. The CfWI has therefore engaged primarily with SHAs as the agreed route to ensuring the views of employers are considered as part of this work. Following NHS reform, it is likely that the CfWI will engage with employer-led Local Education and Training Boards to gain this perspective.

The majority of SHAs report that the OT workforce is in a position of balance or slight oversupply, with no significant increase in demand. Oversupply is being managed through the use of talent pools and a number of SHAs are slightly decreasing commissions. Multi Professional Education and Training (MPET) data shows a small reduction in planned commissions across England for the 2011/12 academic year (DH, 2011e). Some SHAs are undertaking focused work to establish more robust intelligence on OT roles and workforce requirements across sectors and within service delivery settings.

Profession's view²

According to the College of Occupational Therapists (COT), there is an increasing need for OT services as a result of the ageing population and the increase in complex long-term conditions. A further increase in demand may result from the increasing focus on promoting self care and independent living, and from the drive for rehabilitation and reablement services.

The college has also expressed concerns that senior NHS posts are being downgraded, resulting in a loss of professional leadership within the profession (COT, 2012).

² The CfWI engaged with representatives from each profession to inform this report. Although in some cases the source is not explicitly named, this information may be available on a case-by-case basis. Please contact the CfWI if more information is required.

Demographics

Due to the ageing population, the number of people with long-term conditions – including dementia and other progressive conditions – is likely to rise, which may increase demand for OT skills. According to the Office for National Statistics (ONS), the English population is estimated to increase from approximately 52.7 million in 2011 to 60.8 million in 2031, an increase of approximately 15 per cent. Those aged 65 and over are estimated to increase from approximately 8.8 million in 2011 to 13.2 million in 2031, an increase of approximately 51 per cent.

Additional drivers

- The *End of Life Care Strategy* (DH, 2008b) proposed a pathway approach to promote whole systems approaches to end-of-life care. OTs can be involved in a number of stages of the pathway.
- A number of recent case studies have shown that OTs employed in accident and emergency (A&E) services have been effective in preventing the number of admissions and readmissions into hospitals, and supporting early discharge. For example, an early intervention team in Norfolk made a saving of 222 bed days equating to a financial saving of approximately £25,000 (Howard, 2010). Furthermore, working in the A&E environment should allow for OTs to work in a more integrated manner across different teams, providing people with more holistic assessments and comprehensive treatment packages.
- The green paper *Support and aspiration: A new approach to special educational needs and disability* (DfE, 2011) sets out wide-ranging proposals in order to improve outcomes and better support disabled children and children with special educational needs (SEN). Given the role of OTs in maximising children's opportunities for independence in everyday tasks, access to the national curriculum and safety at home, it is possible this may impact on the OT workforce in the future.
- The Department of Health (DH) has released £15 million to improve prosthetic services for military amputees and to create new NHS facilities for prosthetic limb provision and rehabilitation, following a review of services by Dr Andrew Murrison (DH, 2011d). Based on the modelling produced within *A better deal for military amputees* (Murrison, 2011), world-class medical care provided in the field combined with increased use of Improvised Explosive Devices (IEDs) has generated a rise in the surviving number of amputees, which will lead to a sustained increase in the number of amputees who leave the armed forces up to 2020. However, although the additional caseload is likely to be complex, the absolute number is likely to be small. This may further increase the demand for OT services, though demand is unlikely to increase significantly.
- The increased use of telecare can enhance and maintain the wellbeing and independence of people and help to free up resources, reduce the number of acute hospital admissions, and support discharge and intermediate care. The increased use of telecare in the OT workforce may change staff roles and skills mix in order to

deliver more effective services. All OTs will need some level of training to undertake telecare assessments and arrange for the provision of appropriate equipment and services alongside one-to-one contact.

Changes in activity

- It is possible that the current economic climate may lead to increasing mental health needs as a result of job loss, housing repossession and family breakdown. A survey in May 2010 for Mind found that since the latest recession, one in ten workers sought support from their doctors and 7 per cent started taking antidepressants for stress and their mental health needs directly caused by the effects of the recession on their work³ (Mind, 2010). This may increase demand on the OT workforce as they work as responsible clinicians (RC), approved mental health practitioners (AMHPs) and low- and high-intensity cognitive behavioural therapists (CBT) under IAPT, and are therefore considered key to the delivery of mental healthcare.
- OTs have a key role to play in the management of people living with long-term conditions, including older people, due to their skills in developing and implementing care plans to help people retain independence for as long as possible. Approximately 15 million people in England suffer from a long-term condition, and while the number of people with long-term conditions is projected to be broadly stable until 2018 and beyond, the number of those with co-morbid long-term conditions is set to rise from 1.9 million in 2008 to 2.9 million in 2018 (DH, 2010i).
- According to the revised statement of fitness for work (DWP, 2010b), certifying doctors are able to advise that people are 'not fit for work' or 'may be fit for work', where an individual is not necessarily unable to work, but certain adaptations and support from their employer will be needed. It is possible that new statements may increase the number of referrals to occupational health professionals. However, such an increase is unlikely to be substantial, as the majority of statements will be for common health conditions for which simple actions will be appropriate.

³ Based on a Populus poll of 2050 workers

CURRENT AND FORECAST SUPPLY

Existing workforce

Supply

According to the Health Professions Council (HPC) there were 25,009 OTs registered in England as at 3 January 2012 (HPC, 2012). The Health and Social Care Information Centre (HSCIC) Non-Medical Census (HSCIC, 2011a) recorded 17,777 headcount (15,142 full-time equivalent) qualified occupational therapy staff employed in the NHS in England as at 30 September 2010. Table 2 breaks this down according to occupation description.

Table 2: Current qualified NHS workforce – occupational therapists

Staff grade	Headcount (HC)	Full time equivalent (FTE)	FTE/HC
Consultant therapist	27	25	0.9
Manager	639	567	0.9
Therapist	14,897	12,704	0.9
Technician	356	289	0.8
Instructor/teacher	1,881	1,557	0.8
Tutor	1	1	1.0
Qualified staff	17,777	15,142	0.9

Totals may not equal the sum of components.

Source: HSCIC Non-Medical Census (HSCIC, 2011a)

The 2010 Social Services Staffing Collection (SSDS001) covers all staff directly employed by social service departments of Councils with Adult Social Services Responsibilities (CASSRs) as at September 2010, and identified 2350 HC OTs (1890 FTE) working for local authorities in England. This workforce was supported by 2855 (2360 FTE) OT assistants, equipment aids and other officers. Table 3 breaks down the OT workforce by SSDS code and area of work.

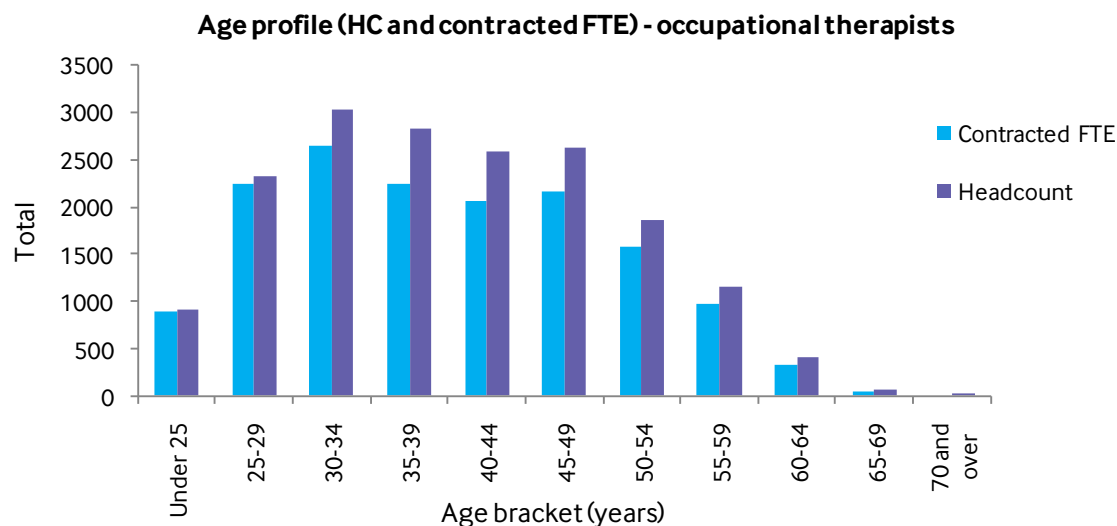
Table 3: SSDS 001 2010 Return, total local authority workforce – occupational therapists

Area of work	SSDS Code	HC	FTE	FTE/HC
Children	2.37	215	160	0.7
Adults	2.46	1510	1230	0.8
Generic provision	2.86	625	500	0.8
Totals		2350	1890	0.8

Source: Community Care Statistics: Social Services Activity, England 2009-10 (HSCIC, 2010b)

Age profile

Figure 1: HC and FTE age profile by 5 year age band, 2011 – occupational therapists



Source: HSCIC Monthly Workforce Extract, April 2011 (HSCIC, 2011b).

Note that the 'Under 25' age bracket only contains those between the ages of 21 and 24, whereas the other groups are in 5-year bands, therefore the relative numbers for that age band in figure 1 will be smaller.

Figure 1 shows the age profile of the OT workforce in the NHS, as at April 2011, by both headcount and FTE. The age profile shows the OT workforce is relatively young, with 53 per cent aged 39 or below (based on contracted FTE). Figure 1 suggests no immediate risk to workforce supply through retirements in the NHS workforce.

Current vacancies and employment

The HSCIC three-month vacancy rate survey reports a vacancy rate of 0.7 per cent for OTs as at 31 March 2010. This rate is higher than the average, 0.5 per cent, reported for all allied health professionals (AHPs).

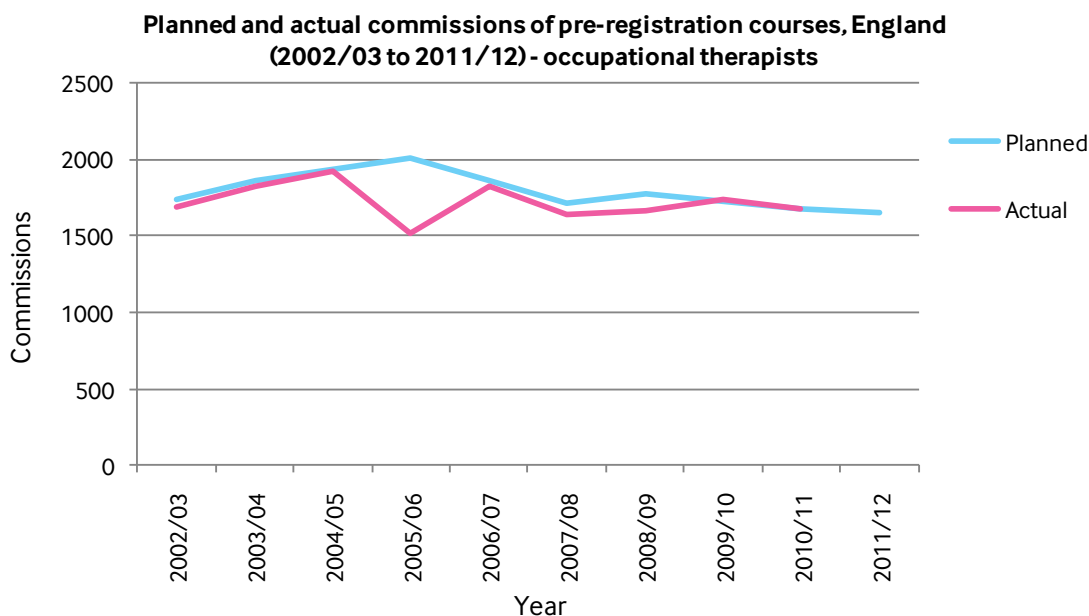
The 2010 local government workforce survey (Local Government Group, 2010) identified both adult and children's OTs as being among the top ten occupations most frequently reported as having retention difficulties, with 15 per cent of authorities reporting retention problems for adult OTs and 13 per cent of authorities for children's OTs.

Students

Registration as an OT is normally obtained by completing an undergraduate degree course. The degree course typically takes three to four years to complete. Postgraduate programmes are also available, which are typically two-year full-time programmes, and will award either a postgraduate diploma in occupational therapy or an MSc in occupational therapy. OT is a regulated profession and as such, registration with the HPC is a prerequisite to practice.

Figure 2 shows the actual and planned commissions for OTs. With the exception of the 2005/06 academic year, the graph shows that planned and actual commissions have remained broadly in line with each other. Planned commissions show a slight reduction for the 2011/12 academic year.

Figure 2: Total national commissions of training places, planned and actual⁴ – occupational therapists



Source: Multi Professional Education and Training (MPET) 02B - Non Medical Education and Training (NMET) Commissions, 2002/03 to 2011/12 (DH, 2011e)

Recruitment

Figures reported to the COT by higher education institutions (HEIs) show that the majority of graduates are gaining employment though figures vary regionally. This regional variation is indicated by data for the academic year 2008 which shows that the reported success rate of new graduates in gaining employment as an OT ranged from 48 per cent to 100 per cent in traditional health and social care settings. Approximately 7 per cent of graduates were employed in non-occupational therapy posts as a result of their role-emerging placements⁵ (COT, 2010).

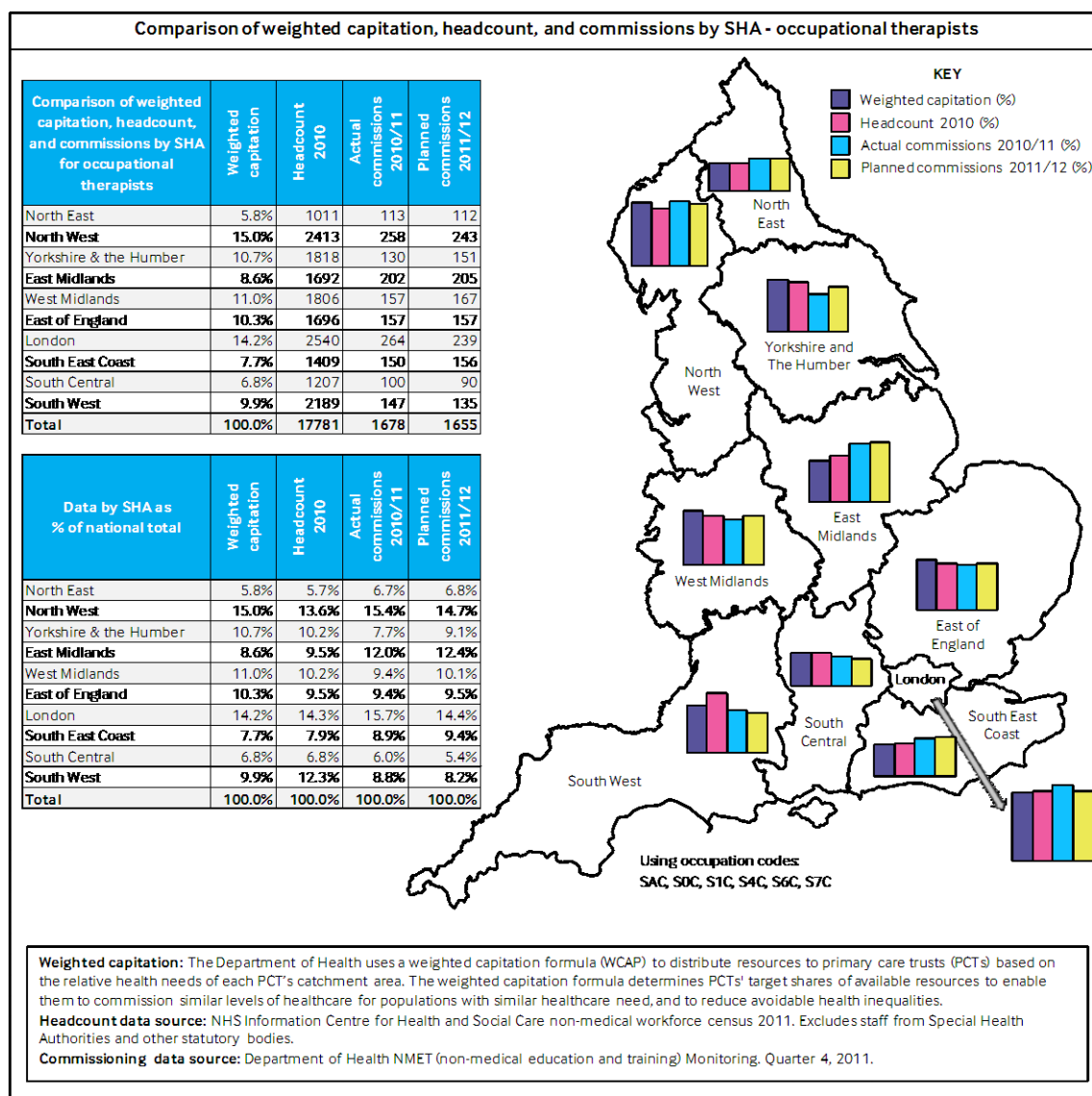
⁴ The 2011/12 planned commissions should be regarded as indicative.

⁵ Role-emerging placements are student practice placements which occur in settings that have previously not experienced or identified an occupational therapy role. The student, guided by an off-site OT, considers the occupational needs of the people in the setting, and either establishes an occupational therapy role or suggests or establishes a relevant project to benefit the service users in that setting (Thew, Hargreaves, Cronin-Davis, 2008).

Geographical distribution

Figure 3 shows the headcount of OTs in each SHA in September 2010 (HSCIC, 2011a), the actual commissions for training in occupational therapy in the academic year 2010/11 and planned commissions 2011/12 (DH, 2011e), and weighted capitation (DH, 2011f).

Figure 3: Map showing NHS staff, planned and actual commissions in relations to weighted capitation by SHA – occupational therapists



Source: HSCIC Census 2011 (headcount); DH NMET Monitoring Quarter 4, 2010/11 (commissions); DH 2011 (weighted capitation).

Based on engagement with SHAs, the following regional variations have been identified:

The South East Coast and South Central SHAs indicate a small oversupply of OTs in their regions, with this staff group featuring in the talent pool. The South Central SHA reports that most organisations are currently able to achieve their placement allocation. Creative 'role emerging' placements are being developed for final year students, which may foster employment opportunities for new graduates. However, the shift in employment opportunities from acute to community needs to be mirrored in the development of community placements, and acute placement capacity is under pressure.

The East of England SHA currently commissions some OTs via the East Midlands and the London SHAs. Figures for the East of England SHA for the 2010/11 and 2011/12 academic years may be showing as part of the London and/or East Midlands SHA data.

The East Midlands SHA reports that current commissioning figures in figure 3 are not representative of the true picture as there is a shared commissioning arrangement for OTs between the East Midlands and Yorkshire and the Humber SHAs.

The East Midlands SHA reports a slight oversupply in the NHS workforce and a need for more robust data and intelligence on the local authority workforce. This will be obtained through local health community teams and used to inform future commissioning plans.

The small reduction in North West SHA commissions reflects higher levels of unemployment for OTs than some other professions, with support being provided through a bank system for new qualifiers and through a placement support network. A workforce profiling project is currently being undertaken across all allied health professions to provide more in-depth analysis and understanding of local service drivers and workforce requirements.

The Yorkshire and the Humber SHA is not experiencing any significant increase in demand, and plans a slight increase in education commissioning to maintain the current balance. The London SHA also indicates supply and demand to be broadly in balance with the possibility of a small undersupply, although local demand is currently being reviewed.

Supply projections

Figure 4a shows that the NHS OT workforce expanded by approximately 6 per cent between 2005 and 2010. CfWI modelling estimates that the supply of OTs available to the NHS and any other sectors in England is forecast to increase to approximately 30,512 HC (25,990 FTE) in 2016, which is a 25 per cent increase from 2010.

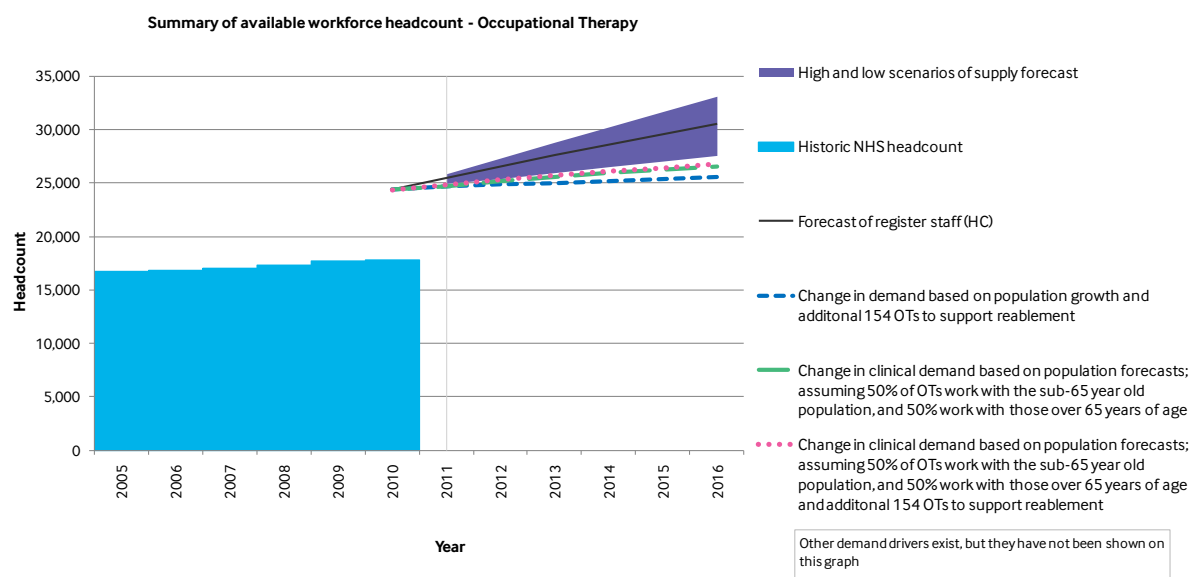
Within the OT model, three demand scenarios have been estimated:

- Change in demand based on population growth and an estimation of additional OTs necessary to support reablement (dashed blue line). This scenario assumes that in addition to the growth necessary to serve the needs of the population, an additional 154 HC will be needed to support reablement (Skelton, J., 2011a). It is therefore estimated that the future demand for OTs in this scenario will be 25,552 HC (21,765 FTE) in 2016.

- Change in clinical demand based on population forecasts. This assumes that 50 per cent of OTs work with those aged 65 or below, and 50 per cent work with those over 65 (green line) (Skelton, J., 2011b). This scenario estimates that the future demand for the OT workforce will be 26,582 HC (22,642 FTE) in 2016.
- Change in clinical demand based on population forecasts and estimation of additional OTs necessary to support reablement. This assumes that 50 per cent of OTs work with the those aged 65 or below, and 50 per cent work with those over 65, in combination with the estimation of additional OTs necessary to support reablement (dotted pink line). This scenario estimates that the future demand for the OT workforce will be 26,741 HC (22,778 FTE) in 2016.

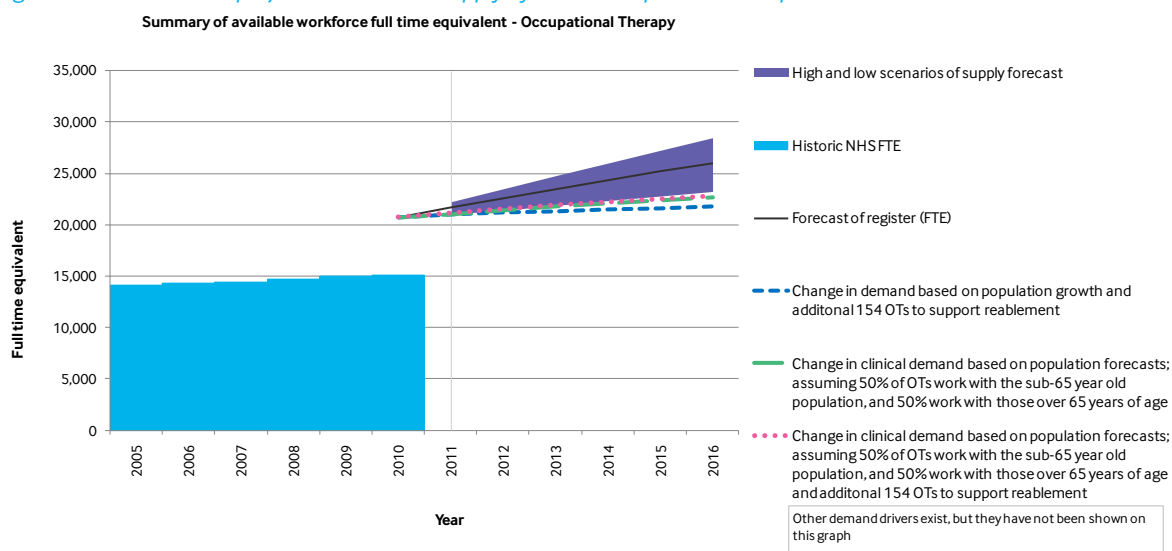
This model assumes that service activity continues to be delivered in the same way as now. We accept that service reconfiguration and skills may alter future demand, and modelling can be adapted as more is understood about these changes. This modelling suggests that supply is increasing at a faster rate than demand, and that the gap between supply and demand is forecast to widen over time.

Figure 4a: Historical and projected workforce supply by HC – occupational therapists



Source: Historical Supply Data is from the HSCIC (2011) and HPC for England Statistics (2010). Supply forecasts are based on HPC data and workforce assumptions. Estimates of requirements use population projections (ONS, 2010) and workforce assumptions.

Figure 4b: Historical and projected workforce supply by FTE – occupational therapists



Source: Historical Supply Data is from the HSCIC (2011) and HPC for England Statistics (2010). Supply forecasts are based on HPC data and workforce assumptions. Estimates of requirements use population projections (ONS, 2010) and workforce assumptions.

CfWI modelling⁶ from 2010 onwards is based on current commissions, assumptions reached by analysing past trends, and engaging with the profession to identify other indications. The most likely scenario (black line) indicating the estimate of future supply uses the agreed baseline assumptions in Table 4. The darker shaded area on the right of the graph shows the forecast range of OTs, and is based on the low and high scenario assumptions in Table 4.

The supply forecasts are based on the HPC register for England, which includes those in both the NHS and non-NHS sectors. According to CfWI supply modelling, there are approximately 6,574 (HC) registered OTs outside the NHS, such as those working in social care, the voluntary sector, education, work and pensions and the private sector. The HPC data also includes non practitioners and those working within the OT scope of practice without direct front-line contact, such as

- those who have retired but remain on the HPC register until their current membership requires renewal, at which point they will leave the register
- those in management posts both in the NHS and private organisations
- those working in academia, and/or providing education to qualifying courses.

⁶ Further details of the modelling used in the CfWI workforce risks and opportunities education commissioning risk summaries (WRO ECRS) can be found in the WRO ECRS methodology report.

Table 4: Summary of assumptions used in the supply forecast – occupational therapists

Variable	Low scenario	Baseline	High scenario
Training pipeline	10% 2 years, 71% 3 years, 18% 4 years, 1% 5 years	11% 2 years, 74.4% 3 years, 14.6% 4 years	As baseline
Trainee commissions	Commissions 5% lower	As current	Commissions 5% higher
Training attrition	12.5%	10%	7.5%
Trainees registration on graduation	90%	92.5%	95%
International recruits	50% of baseline	165 per year	150% of baseline
International leavers	0 per year	0 per year	0 per year
Young leavers	1.5% of Workforce	1% of Workforce	0.5% of Workforce
Future return to practice	50% of baseline	117 per year	150% of baseline
FTE/HC ratio	99% of baseline	0.85	101% of baseline
Retirements	Retirement profile offset by 2 years earlier, and 50% greater	Retirement profile as 2007 – 2010	Retirement profile offset by 2 years later

While good data has been obtained on workforce joiners, there is a lack of data about young leavers from the workforce (those who leave the OT workforce in addition to retirements). This model assumes that between 0.5 per cent and 1.5 per cent of the workforce will leave the workforce in addition to those who leave due to retirement.

Interplay with related groups

OTs work with a number of other workforce groups. For example:

- Occupational therapy is one of the five key professions delivering mental health services. OTs work in collaboration with other mental health practitioners as part of multidisciplinary teams.
- OTs work in multidisciplinary teams such as early discharge teams in accident and emergency.
- OTs working in social care advise on home adaptations and equipment.
- OTs work with social workers, physiotherapists, nurses and other practitioners in multidisciplinary contexts to support people with long-term conditions.
- OTs work with children, both in schools and in the home, in order to maximise children's development opportunities to support independence in everyday tasks, learning, play and access to the national curriculum.

CONCLUSION

CfWI modelling indicates that there is currently a sufficient supply of OTs, but with supply forecasts exceeding demand estimates. This view was further reflected through engagement with a number of SHAs such as the South East Coast, South Central and East Midlands SHAs, who reported marginal oversupply in their regions. Analysis of the NHS age profile shows that the OT workforce in the NHS is a relatively young workforce. However, there appears to be retention difficulties in the OT workforce.

There is the risk that the supply-demand gap is forecasted to widen with supply outstripping demand. However, it is important to consider that demand for services provided by the OT workforce is likely to increase as a result of the ageing population, the prevalence of long-term conditions and the potential rise in mental health conditions. A further increase in demand may be seen from specific policy initiatives such as reablement and vocational rehabilitation, and more generally from supporting the occupational health agenda.

OTs work across a variety of sectors such as the NHS, social care, the voluntary sector, education, work and pensions and the private sector (e.g. insurance). For this reason, it would be beneficial for education training commissioners and workforce planners to consider the demand from non-NHS sectors in their planning. This will become increasingly important following the reforms to the health and social care system.

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