



The ALIGNS programme (AHPs Leading InteGration between Social Care and Health)

Annex to full report



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Introduction to the Annex

The detail in this Annex supplements information provided in the final full report from the ALIGNS project.

For ease of reference the section of the main report that the Annex enhances is listed below:

Annex 1 includes additional workforce data referred to in section **4.1.2. Occupational Therapy Workforce data**

Annex 2 sets out the detailed report of the Kent and Medway case study site Proportionate Care and Trusted Assessment review referenced in section **4.4.5.3**.

Annex 3 is comprised of the Enhanced Care Integrated Team proof of concept mentioned in **section 4.4.8**

Annex 4 sets out the detail about the strengthening the voice of Occupational Therapists in integration workshops in section **4.5.5**

Annex 5 is a table of the CQC report outcomes mentioned in the general discussion: overview of the quality and learning and improvement innovation outcomes for the authorities that were inspected during ALIGNS, mentioned in section **5.1**

ANNEX 1: Skills for Care Occupational Therapists' employment profile

Table A1: Occupational Therapists' employment profile (September 2024) all sectors – Skills for Care data by authority¹

Data fields	Buckinghamshire		Oxfordshire		Berkshire West		Reading		Wokingham	
Permanently employed (%)	75		98		67		94		100	
Temporarily employed (%)	13		2		7		0		0	
Indirectly employed (%)	13		0		27		6		0	
Work full-time (%)	63		51		67		56		40	
Work part-time (%)	37		49		33		44		60	
FTE filled post ratio	0.86		0.80		0.89		0.8		0.84	
Number of filled posts	25		75		25		25		10	
Experience in the sector	Average number of years in the sector 4.8		Average number of years in the sector 11		Average number of years in the sector 7.3		Average number of years in the sector 11.9		Average number of years in the sector Data not available	
	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector
	6	10 or more	43	10 or more	40	10 or more	58	10 or more	20	10 or more
	63	3-9	43	3-9	20	3-9	24	3-9	70	3-9
	31	Less than 3	14	Less than 3	40	Less than 3	18	Less than 3	10	Less than 3

¹ No data available from Royal Borough of Windsor and Maidenhead

Experience in role	Average number of years in the role 3.2		Average number of years in the role 7.3		Average number of years in the role 3.7		Average number of years in the role 2.4		Average number of years in the role 2.4	
	%	Number of years in role								
	4	10 or more	25	10 or more	13	10 or more	6	10 or more	20	10 or more
	40	3-9	43	3-9	27	3-9	29	3-9	70	3-9
	56	Less than 3	32	Less than 3	60	Less than 3	65	Less than 3	10	Less than 3
Gender	Female	81%	Female	92%	Female	91%	Female	94%	Female	100%
	Male	19%	Male	8%	Male	9%	Male	6%	Male	0%
Ethnicity	Ethnic group	%								
	White	75	White	97	White	100	White	93	White	90
	Black/African/Caribbean/Black British	19	Black/African/Caribbean/Black British	3	Black/African/Caribbean/Black British	0	Black/African/Caribbean/Black British	7	Black/African/Caribbean/Black British	10
	Asian/Asian British	6	Asian/Asian British	0						
	Mixed	0								
	Other	0								
Nationality	Nationality	%								
	British	100	British	89	British	100	British	82	British	87
	Non-EU	0	Non-EU	6	Non-EU	0	Non-EU	13	Non-EU	8
	EU	0	EU	4	EU	0	EU	5	EU	5
Age	Average age (years) 41.3		Average age (years) 42.7		Average age 40.3		Average age 41.5		Average age 48.4	
	Age (years)	%								
	< 25	0	< 25	5	< 25	0	< 25	0	< 25	0
	25-54	88	25-54	78	25-54	73	25-54	88	25-54	70
	55 & >	12	55 & >	17	55 & >	27	55 & >	12	55 & >	30

Data fields	Slough		Bracknell Forest		Kent		Medway		Portsmouth	
Permanently employed (%)			84		98		95		100	
Temporarily employed (%)			0		2		5		0	
Indirectly employed (%)			16		0		0		0	
Work full-time (%)	91		75		64		73		65	
Work part-time (%)	9		25		36		27		35	
FTE filled post ratio	0.98		0.91		0.87		0.91		0.82	
Number of filled posts	25		10		100		25		25	
Experience in the sector	Average number of years in the sector 8.8		Average number of years in the sector Not available		Average number of years in the sector 11.8		Average number of years in the sector 10.6		Average number of years in the sector 12.5	
	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector
	34	10 or more	42	10 or more	51	10 or more	48	10 or more	58	10 or more
	65	3-9	33	3-9	41	3-9	27	3-9	41	3-9
	1	Less than 3	25	Less than 3	8	Less than 3	25	Less than 3	1	Less than 3
Experience in role	Average number of years in the role 5.6		Average number of years in the role 4.8		Average number of years in the role 7.9		Average number of years in the role 2.6		Average number of years in the role 8.7	
	%	Number of years in role	%	Number of years in role	%	Number of years in role	%	Number of years in role	%	Number of years in role
	23	10 or more	16	10 or more	34	10 or more	1	10 or more	27	10 or more
	47	3-9	49	3-9	33	3-9	41	3-9	47	3-9
	31	Less than 3	35	Less than 3	33	Less than 3	58	Less than 3	26	Less than 3

ALIGNS: Annex

Gender	Female	85%	Female	91%	Female	94%	Female	99%	Female	96%
	Male	15%	Male	9%	Male	6%	Male	1%	Male	4%
Ethnicity	Ethnic group	%								
	White		White		White	90	White	85	White	87
	Black/African/ Caribbean/ Black British		Black/African/ Caribbean/ Black British		Black/African/ Caribbean/ Black British	1	Black/African/ Caribbean/ Black British	0	Black/African/ Caribbean/ Black British	9
	Asian/ Asian British		Asian/ Asian British		Asian/ Asian British	2	Asian/ Asian British	5	Asian/ Asian British	0
	Mixed		Mixed		Mixed	6	Mixed	9	Mixed	0
	Other		Other		Other	1	Other	0	Other	4
Nationality	Nationality	%								
	British	78	British	99	British	88	British	91	British	87
	Non-EU	15	Non-EU	1	Non-EU	9	Non-EU	7	Non-EU	1
	EU	7	EU	0	EU	3	EU	2	EU	12
Age	Average age 36.9		Average age 44.1		Average age 40.1		Average age 42.9		Average age 44.4	
	Age (years)	%								
	< 25	0	< 25	1	< 25	8	< 25	6	< 25	0
	25-54	90	25-54	70	25-54	79	25-54	75	25-54	76
	55 & >	10	55 & >	29	55 & >	13	55 & >	19	55 & >	24

Data fields	Southampton		Surrey Heartlands		East Sussex		West Sussex		Brighton & Hove	
Permanently employed (%)	100		89		89		98		100	
Temporarily employed (%)	0		1		6		2		0	
Indirectly employed (%)	0		10		5		0		0	
Work full-time (%)	68		53		51		62		57	
Work part-time (%)	32		47		49		38		43	
FTE filled post ratio	0.72		0.76		0.78		0.87		0.85	
Number of filled posts	10		75		75		100		25	
Experience in the sector	Average number of years in the sector 12.4		Average number of years in the sector 6.6		Average number of years in the sector 11.8		Average number of years in the sector 8.5		Average number of years in the sector 11	
	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector	%	Number of years in sector
	58	10 or more	31	10 or more	45	10 or more	33	10 or more	53	10 or more
	41	3-9	34	3-9	37	3-9	42	3-9	45	3-9
	9	Less than 3	35	Less than 3	17	Less than 3	24	Less than 3	2	Less than 3
Experience in role	Average number of years in the role 2.7		Average number of years in the role 3.2		Average number of years in the role 4.3		Average number of years in the role 5.2		Average number of years in the role 5.3	
	%	Number of years in role	%	Number of years in role	%	Number of years in role	%	Number of years in role	%	Number of years in role
	20	10 or more	4	10 or more	12	10 or more	18	10 or more	27	10 or more
	41	3-9	40	3-9	37	3-9	35	3-9	14	3-9
	40	Less than 3	56	Less than 3	51	Less than 3	47	Less than 3	59	Less than 3

ALIGNS: Annex

Gender	Female	98%	Female	90%	Female	83%	Female	92%	Female	
	Male	2%	Male	10%	Male	17%	Male	8%	Male	
Ethnicity	Ethnic group	%								
	White	82	White	92	White	92	White	93	White	90
	Black/African/ Caribbean/ Black British	17	Black/African/ Caribbean/ Black British	2	Black/African/ Caribbean/ Black British	5	Black/African/ Caribbean/ Black British	3	Black/African/ Caribbean/ Black British	3
	Asian/ Asian British	1	Asian/ Asian British	2	Asian/ Asian British	1	Asian/ Asian British	1	Asian/ Asian British	0
	Mixed	0	Mixed	4	Mixed	2	Mixed	3	Mixed	6
	Other	0	Other	0	Other	0	Other	0	Other	1
	Nationality	Nationality	%	Nationality	%	Nationality	%	Nationality	%	Nationality
British		83	British	88	British	89	British	87	British	91
Non-EU		16	Non-EU	7	Non-EU	4	Non-EU	9	Non-EU	4
EU		1	EU	5	EU	7	EU	4	EU	5
Age	Average age 48.5		Average age 46.5		Average age 46.8		Average age 43.5		Average age 49.5	
	Age (years)	%								
	< 25	1	< 25	0	< 25	1	< 25	2	< 25	1
	25-54	66	25-54	73	25-54	68	25-54	78	25-54	65
	55 & >	33	55 & >	27	55 & >	31	55 & >	20	55 & >	34

ANNEX 2: Kent & Medway proportionate care & trusted assessment task and finish group

A2. 1 Introduction

Kent and Medway is one of the six Integrated Care Systems (ICSs) that cover the South East of England.

The ALIGNS Kent and Medway case study site group agreed that a deep dive into the different approaches that service providers, in Kent and Medway, take to Proportionate Care (PC) and Trusted Assessment (TA) would provide valuable insight into their services (see full report main findings 4.4.5.3).

A2. 2 Approach to this case study site project

A task and finish group with sixteen members from across social care and health organisations in Kent and Medway was established. The members were invited to provide comments on the two draft bespoke data collection forms about approaches to PC and TA.

Once finalised the members of the task and finish group were asked to populate the forms (A2.5 & A2.6). The report below is based on the data collected and subsequent discussions.

The task and finish group members represented the following services in Kent and Medway:

1. Dartford and Gravesham NHS Trust: Occupational Therapy
2. East Kent Hospitals University Foundation Trust: Inpatient Therapies
3. HCRG (Health Care Resourcing Group) –Medway and Swale: Rapid Response and Intermediate Care
4. Kent Community Hospital: Rehabilitation and Therapies
5. Kent County Council: Adult Social Care, Occupational Therapy Service
6. Maidstone and Tunbridge Wells NHS Trust: Occupational Therapy
7. Medway Community Healthcare: Intermediate Care
8. Medway Unitary Authority: Adult Social Care

The key functions that these services provide, for those with lived experience and their carers are summarised as follows:

1. The acute sector plans the discharge to community.
2. NHS community services provide intermediate care services with a focus on facilitating discharge and admission avoidance. Although in Medway admission avoidance is included in the Urgent Response pathway
3. Social care occupational therapy adult services promote independence, wellbeing, and safety for adults with care and support needs. The service undertakes assessments for suitable equipment, adaptations and proportionate care, and support needs for persons living in their own home and complies with the legal duties under the [Care Act 2014](#)

A2.3 Proportionate Care data

The data about proportionate care in Kent and Medway was collected under the following headings:

1. Approach to governance of proportionate care
2. Model of proportionate care
3. Background to approach to delivering Proportionate Care
4. Evidence of the effectiveness of model of Proportionate Care
5. The staff delivering Proportionate Care (assessing for)
6. Formal Training of staff to deliver proportionate care
7. Education and Training of staff delivering proportionate care
8. Opportunities and Challenges of delivering proportionate care

A2.3.1 Approach to governance of proportionate care

Clinical governance is the framework that ensures the quality and safety of patient care and minimises risk. Three organisations have a clear strategic approach to PC governance, and one organisation reported their approach is under development. It is not always clear who, in an organisation, is the person responsible for PC. Furthermore, just two respondents reported that their organisation has a clear strategic approach as to who should be trained to provide this type of care.

A2.3.2 Model of proportionate care

Of the seven organisations that reported they provide a PC process their approach to delivering PC is very similar and based on '*maximising the person's abilities and strengths ... and support needs*' while '*minimising risk*'.

A2.3.3 Background to approach to delivering Proportionate Care

The responding organisations have taken a very carefully considered approach to delivering PC. For some this has been over a long period of time, and they have refined their approach, for others it is a more recent development. Different influences have guided the latest models:

- any perceived reduction in provision of care must be underpinned by the right level of care and support with the right equipment and adaptations;
- where appropriate all of a group of staff (e.g. Band 6 OTs) should be trained to deliver PC;
- relevant service specifications;
- robust evidence from other providers;
- other benefits to the service i.e. efficiency and effectiveness.

A2.3.4 Evidence of the effectiveness of the model of Proportionate Care

Three of the listed organisations collect data about the effectiveness of their PC, primarily to demonstrate effectiveness and help with problem solving. None of this data is centrally stored or shared.

A2.3.5 The staff delivering Proportionate Care

Regulated OTs are the main healthcare group that delivers PC (reported by seven providers). Other groups include:

- Enablement staff along with OT staff (e.g. Band 3 and Band 2 enablers)
- Physiotherapists
- Home First Assessors
- Social care officers and associate practitioners
- Local care providers

A2.3.6 Formal training of staff to deliver proportionate care

The two social care providers and three of the health providers reported that they enable their staff who deliver PC to be formally trained. This may be internally provided or outsourced. There is concern that the current approach to training is largely unsustainable and there is a suggestion it could be included as part of the mandatory offer for these services.

A2.3.7 Education and Training models for staff delivering proportionate care

Two organisations who reported using external training providers use either A1 Training Solutions or a local organisation: OT4Independence. The courses cover:

- theory including relevant legislation
- equipment demonstrations
- practical assessment

The reported assessment process is based on competencies. The approach to judging the competencies varies:

- a taught component and peer review of competencies;
- practical assessment and formal sign off of competencies;
- supervisor observation.

In some organisations staff are required to demonstrate these competencies annually. Lack of funding for these programmes may limit the frequency of reassessment.

A2.3.8 Opportunities and challenges of delivering proportionate care

The reported **opportunities** to deliver PC included:

- Benefits for those with lived experience
- Potential for improved efficiency
- Improved working relationships across the multi- agencies including the private sector
- A more proactive effective service

Despite these positive observations the list the respondents provided of **challenges** was extensive and is grouped as follows:

- The person's and carer's reluctance to have perceived reduced quality of care
- Reticence of care provider agencies
- Maintenance of specialist training with high staff turnover
- Staff confidence
- Limited funding
- Liaison with social work colleagues to facilitate assessment
- Time pressures to undertake all the necessary assessment, reviews and implementation



'Delivering proportionate care enables us to think more proactively and to provide the right amount of resource to each patient e.g., striving to maintain/increasing someone's independence to reduce the care requirement to as minimal as possible.'

A2. 4 Trusted Assessment

TA is an assessment carried out by a trusted individual on behalf of a care provider. In 2022 the South East Social Care Alliance (SESCA) developed proforma agreements to support new TA schemes. All documents relating to this scheme can be accessed via SESCOA's Trusted Assessor Scheme Review document².

A key activity within the task and finish group was to explore shared understanding of the role of a Trusted Assessor. This term is not routinely used in healthcare providers.

Proposed definition of Trusted Assessor

CQC guidance³ states:

Trusted assessors must have the qualifications, skills, knowledge and experience needed to carry out health and social care assessments, and to formulate plans of care on behalf of adult social care providers. Providers must be confident that Trusted Assessors understand the needs their service can meet, and that the discharges to their service they arrange will be appropriate.

Specific employment and accountability arrangements must be set out in **Trusted Assessor agreements**. Adult social care providers will always retain responsibility for meeting legal

²<https://docs.google.com/document/d/1M7ETlqRygYbi4cybGbHbCyQGwIDmkRT8FP23TIP4g3A/edit?tab=t.0#heading=h.3omwhx3jpmjl> accessed 16/10/2025.

³https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf accessed 07/07/2025

requirements in relation to assessments and care plans. According to the CQC these agreements can take a variety of forms, between provider organisations (e.g. NHS and adult social care), and will include:

- agreed protocols on who carries out assessments,
- competencies required,
- review mechanisms.

Welsh Government guidance⁴ states:

A Trusted Assessor role is defined as: A specific role, with the associated skills and competence, to undertake a proportionate assessment on behalf of another organisation to support a discharge from hospital to the persons next stage in their care journey.

A Trusted Assessor function is defined as: A professional trained, with the associated skills and competence, to undertake a proportionate assessment on behalf of another organisation to support a discharge from hospital to the persons next stage in their care journey as part of their current role.

A Proportionate Assessment is defined as: An assessment which is proportionate to the request and/or the presenting need, recognising that the location in which it is undertaken may not be the best place to fully understand the person's needs and support networks.

Members of the task and finish group suggested the following definition.

A Trusted Assessor is a professional, often from health or social care (including voluntary and third sector), who is trained and authorised to conduct assessments for specific needs, like home adaptations or hospital discharge, on behalf of another organisation or service.

The data about TA in Kent and Medway was collected under the following headings:

1. Approach to governance of Trusted Assessment
2. Model of Trusted Assessment
3. The Trusted Assessors
4. Formal Training of Trusted Assessors
5. Education and Training of Trusted Assessors
6. Evidence of the effectiveness of model of Trusted Assessment

⁴ NHS Wales (2022) Guidance Module 2 Trusted Assessor for Hospital Discharge For Adults

A2.4.1 Approach to governance of trusted assessment

Five organisations provided information about the governance of TA. Most notably Kent County Council (KCC) reported robust governance with a clear TA agreement in place and a senior responsible lead identified. Two of the health providers stated they have agreements in place. It is recognised that the different IT systems make sharing of information really difficult and that may result in an apparent need to repeat the assessment. One respondent noted that the funding may come from a social care budget.



'We do have a trusted assessor agreement; however, this is currently not accepted. For example, we handover to social care and they will complete their care act assessment on top of this.' Health provider

A2.4.2 Model of Trusted Assessment

Four providers shared information about their models of Trusted Assessment.

Model a) For this well established social care based model they

- I. provide training to all TAs to enable them to assess for and prescribe minor equipment and adaptations;
- II. provide training to health clinicians for enable them to assess for and order seating options, bathing and showering equipment;
- III. share health therapy team goals with social care enablement teams, particularly in West Kent.

Model b) The main route is from colleagues in the acute hospital who send referrals detailing patient information about goal setting, moving and handling plans etc. The initial assessment information provided by the acute hospital may be limited and not sufficient to enable staff to continue assessments and treatments. The rapid response team often respond to deteriorating patients in their own home and provide a bridging of care service. When the people are referred to social care, their care plan and moving & handling plan are shared with colleagues in social care, which helps them when they review the person's needs and provide the appropriate packages of care, in line with the trusted assessment model.

Model c) Equipment provision TA is used across services within the Trust and for discharge to other organisations. There are health and social care panels for funding and approval of bespoke or expensive equipment. The Kent and Medway Care Record (KMCR) is a centrally held moving and handling record completed for all patients who have formal care handover of moving and handling care plan. The KMCR is printed and sent to care agencies to deliver the care advised. This model reduces duplication for staff and patients and results in a single proportional care record for each patient, which can be amended as the service user passes through the services. Home First assessors are able to complete social care needs assessment and document this directly into the Council records and action any provision of future long term care needs.

Model d) Similar to model c, Integrated model of person centred assessment is followed by both health and social care professionals who trust, share and build on each other's assessments via the KMCR.

A2.4.3 The Trusted Assessors

The term Trusted Assessor is not used by all health and social care provider organisations. However, the majority do and cite regulated OTs as the key professional group involved in TA. From this data set it is important to note that other key staff (regulated and non-regulated) carry out assessments:

- Regulated e.g., social workers, physiotherapists, nurses, nursing associates
- Non-regulated e.g., officers (social care, housing association); coordinators (health and social care), Home First assessors, navigators, enablement workers and therapy assistants.

A2.4.4 Training and assessing the Trusted Assessors

The responding organisations offer a variety of formal or informal training. For example,

- I. Two day training course provided by NRS Healthcare followed by internal assessment
- II. Competence set developed and signed off internally
- III. Hybrid of external and internal training

The organisations that provide regular update training for Trusted Assessors do so on an annual basis.

A2.4.5 Evidence of the effectiveness of model of Trusted Assessment

Two organisations reported that data is collected to:

- help with decision making;
- inform business case development and problem solving;
- help with the understanding and development of the system/care processes;
- to help understand the needs and expectations of those with lived experience.

TA is also a better use of public funds and leads to better outcomes for the people they support

A2.5 ALIGNS Proportionate care data collection tool

Background

This data collection tool relates solely to Proportionate Care (PC). The aim of developing this tool is to capture the different approaches to PC across the Kent & Medway ICS (integrated Care System).

Part 1: The service that provides Proportionate Care

Please provide background information about the service reported in this tool

	Response	
Location of service (please tick all that apply)	Medway	
	North Kent	
	East Kent	
	West Kent	
Name of the service		
Lead organisation		
Description of the functions of the service/team		
Lead contact person (name and email)		

Part 2: Organisation's governance approach to Proportionate Care

Please tick all that apply.

The service has the following:	Yes	No	Don't know
A clear strategic approach to Proportionate Care			
A clear strategic approach as to who should be trained to provide Proportionate Care			
There is a lead for Proportionate Care			

Part 3: Organisation's model of Proportionate Care

In the box below please briefly outline your model(s) of Proportionate Care

Part 4: Background to delivering Proportionate Care

In this section please briefly explain how your organisation decided on the approach to proportionate care.

Part 5: Evidence of the effectiveness of your model of Proportionate Care

Please provide the following information about any data collected in support of your model of Proportionate Care

Statement about PC data	Response		
	Yes (please tick if appropriate)	If YES state type of data (e.g. quantitative/ qualitative)	No (please tick if appropriate)
A/ Data is collected about the approach to PC			
The reason the data has been collected. (please tick all that apply):			
To help with decision making/ business case development			
To help with problem solving			

To develop a greater understanding of the system/care processes			
To improve processes			
Understand those with lived experience, their needs and expectations			
Other reasons: please describe in box below			

	Yes	No
B/Has the data been shared?		
C/ Have there been any formal outputs? Please note in the box below		

Formal outputs about Proportionate Care

Part 6: The staff delivering Proportionate Care

Please tick all that apply

The following groups of staff may be developed to deliver proportionate care	Yes	No	Don't know
Regulated (HCPC registered) Occupational Therapists employed in health			
Regulated (HCPC registered) Occupational Therapists employed in social care			

Non-regulated (non HCPC registered) Occupational Therapy staff			
Other groups of staff who provide proportionate care. Please note in the box below.			

Part 7: Formal Training of staff to deliver proportionate care

Please tick all that apply

The following groups of staff receive formal education and training to deliver proportionate care	Yes	No	Don't know
Regulated (HCPC registered) Occupational Therapists employed in health			
Regulated (HCPC registered) Occupational Therapists employed in social care			
Non-regulated (non HCPC registered) Occupational Therapy staff			
Others (please list in box below any other groups who receive formal training)			

Part 8: Education and Training of staff delivering proportionate care

Please provide the following information

Outline of the education and training of staff to deliver proportionate care	
Assessment process that ensures appropriate knowledge and skills of all staff delivering proportionate care	
Cycle of reassessment (i.e. how often do staff have to demonstrate their knowledge and skills to deliver proportionate care?)	

Part 9: Challenges and opportunities/benefits of delivering proportionate care

In the box below please list any challenges and opportunities associated with your model of proportionate care delivery.

Part 10: Any other comments

Please add, in the box below, any additional points about proportionate care that have not been captured in Parts 1-9

Thank YOU

A2.6 ALIGNS Trusted Assessment data collection tool

Background

This data collection tool relates solely to Trusted Assessment. The aim of developing this tool is to capture the different approaches to Trusted Assessment across the Kent & Medway ICS (integrated Care System).

Part 1: The service that provides Trusted Assessment

Please provide background information about the service reported in this tool

	Response	
Location of service (please tick all that apply)	Medway	
	North Kent	
	East Kent	
	West Kent	
Name of the service		
Lead organisation		
Description of the functions of the service/team		
Lead contact person (name and email)		

Part 2: Organisation's governance approach to Trusted Assessment

Please tick all that apply.

The service has the following:	Yes	No	Don't know
A Trusted Assessor Agreement between Health and Social Care			
A clear strategic approach as to who should be trained to be a Trusted Assessor?			

An agreement about whether the Trusted Assessor approach can be used in all social care services*			
There is a lead for Trusted Assessment			

* If no please state, in box below, to which social care services TA does not apply

Part 3: Organisation's model of Trusted Assessment

In the box below please briefly outline your model(s) of Trusted Assessment

Part 4: The Trusted Assessors

Please tick all that apply

The following groups of staff may be developed as Trusted Assessors	Yes	No	Don't know
Regulated (HCPC registered) Occupational Therapists employed in health			
Regulated (HCPC registered) Occupational Therapists employed in social care			
Non-regulated (non HCPC registered) Occupational Therapy staff			

Others (please list in box below any other groups you develop to be Trusted Assessors)				
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Part 5: Formal Training of Trusted Assessors

Please tick all that apply

The following groups of staff receive formal education and training to be a Trusted Assessor	Yes	No	Don't know
Regulated (HCPC registered) Occupational Therapists employed in health			
Regulated (HCPC registered) Occupational Therapists employed in social care			
Non-regulated (non HCPC registered) Occupational Therapy staff			
Others please list below any other groups who receive formal training			

Part 6: Education and Training of Trusted Assessors

Outline of the education and training of Trusted Assessors	
Assessment process that ensures appropriate knowledge and skills of all Trusted Assessors	
Cycle of reassessment (i.e. how often do Trusted Assessors have to demonstrate their knowledge and skills?)	

Part 7: Evidence of the effectiveness of your model of Trusted Assessment

Statement about Trusted Assessment data	Response		
	Yes (please tick if appropriate)	If YES state type of data (e.g. quantitative/ qualitative)	No (please tick if appropriate)
A/ Data is collected about the approach to TA			
The reason the data has been collected. (please tick all that apply):			
To help with decision making/ business case development			
To help with problem solving			
To develop a greater understanding of the system/care processes			
To improve processes			
Understand those with lived experience, their needs and expectations			
Other reasons: please describe in box below			

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	Yes	No
B/Has the data been shared?		
C/ Have there been any formal outputs?*		
Please note in the box below.		

Part 8: Any other comments

Please add, in the box below, any additional points about Trusted Assessment that have not been captured in Parts 1-7

Thank YOU

ANNEX 3: Enhanced practice and enhanced care as enablers to AHP integration across social care and health

This annex supplements the information provided in the end of programme report section 4.4.8.1.

Enhanced practice and enhanced practice programmes are activities listed under Dimension 4 of the AHP integration framework. A proof of concept was developed to further understand the role of enhanced practice and enhanced care in enabling integration. There were two key components: Enhanced Care Integrated Team and ALIGNNS education and career development framework.

The first stage was to agree some principles for the **Enhanced Care Integrated Team proof of concept (ECIT)**. The principles developed and tested were identified from two models: Enhanced Supportive Care⁵ and Enhanced Health in Care Homes⁶.

a) Enhanced Supportive Care, a model which was adopted in the UK in 2016 and is underpinned by **providing earlier access to multiprofessional, coordinated care for patients** from the point of cancer diagnosis. As a **proactive model** of care, it stands as a contrast to providing access to a multidisciplinary team once a patient has reached a crisis point, or when their prognosis has become sufficiently poor that they are able to access traditional end-of-life services. While enhanced supportive care has enabled early palliative care, as it has become more embedded in the UK, **it has taken on a wider remit for patients living longer with cancer and other long term conditions and the management of side effects**. Furthermore, enhanced supportive care has been shown to **support the wider healthcare system by creating capacity within the NHS, reducing demand on hospital services and saving money**.

b) Enhanced Health in Care Homes (EHCH) is an approach whereby **a clinician with advanced assessment and clinical decision-making skills should carry out a proactive and comprehensive personalised assessment of need** within 7 working days of admission or re-admission to the care home. The multidisciplinary team (MDT) provides oversight and a broad range of interventions. In this model it is **essential that commissioned proactive and responsive therapy services (e.g. speech and language, dietetics and specialist falls interventions) are part of the MDT and readily available**.

It was proposed that the ECIT would be OT/AHP led. It would include OTs from social care, acute care, community care and primary care, working at an enhanced level of practice; enhanced care workers; social workers; other AHPs (e.g. physiotherapists, speech and language therapists) nurses and rehabilitation assistants. Central to an ECIT is a Transfer of Care Hub (ToCH). ToCHs require an integrated multi-disciplinary team across the health, social care and voluntary sectors to ensure all partners are involved in delivery. They may operate at trust, place, or system-level.

⁵ Monnery D, Droney J. Enhanced supportive care. *Br J Hosp Med (Lond)*. 2024 Mar 2;85(3):1-8. doi: 10.12968/hmed.2023.0416. Epub 2024 Mar 27. PMID: 38557099

⁶ <https://www.england.nhs.uk/community-health-services/ehch/>

ALIGNS career development and education development framework

The origin of the **ALIGNS career development and education development framework proof of concept** principles/themes were identified from the NHS England Aspirant Cancer Career and Education Development (ACCEND) Programme .

The overall purpose of the ACCEND framework is to support healthcare professionals at all levels of practice (supportive, assistive, registration, enhanced, advanced, consultant and pre-registration) who provide care to people with cancer in both generalist (all patient facing healthcare roles) e.g. practice nurse, social prescriber and specialist roles (those specialising in cancer care) e.g. clinical nurse specialist, oncology allied health professional such as a dietitian or physiotherapist by providing guidance on each of the three components:

Component 1: Core capabilities in practice

Using the four pillars of professional practice (clinical practice, leadership and management, education and research) high level core cancer capabilities in practice across seven domains (Box A1) are identified to enable practitioners to contextualise the capabilities for the environment of care in which they work, and the job/roles adopted for each level of practice.

Box A1 Seven Domains of the ACCEND framework

Domain A: Person centred collaborative working

Domain B: Assessment, investigations and diagnosis

Domain C: Condition management, treatment and planning

Domain D: Leadership and collaborative practice

Domain E: Developing evidence-based practice and improving quality; Research

Domain F: Developing evidence-based practice and improving quality; Service evaluation and quality improvement

Domain G: Educating and developing self and others

Component 2: Education framework

The Education framework sets a standard for core cancer knowledge for the workforce through defined learning outcomes and knowledge expectations and offers guidance on education, training and development opportunities to achieve the core cancer knowledge, evidence the capabilities in practice and identify further learning to meet role requirements and career aspirations.

Component 3: Cancer career pathway

The pathway provides insight and transparency into the characteristics required to work at each level and provides examples of the level of knowledge and skill required for working at each level of practice. The career pathway indicates the levels as opportunities for progression however, it is important to note, that remaining practicing at a specific level of practice is also a valuable endpoint.

Learning from the very successful ACCEND programme it is proposed that an ALIGNS career development and education development framework is developed for AHPs with a focus on integration. The framework would include three components (illustrated in figure 14 of the project report:

- I. Career Pathway
- II. Core capabilities in practice
- III. Education framework

Testing the proof of concept principles

The ECIT proof of concept principles were tested with three clinical teams, in Buckinghamshire, that have responsibility for reablement, rehabilitation, promoting independence and community support. The purpose of testing the principles was to gain a greater understanding as to extent to which the form and function of these three teams aligned to the principles listed in the proof of concept as set out in Tables A2 and A3.

Table A2 Findings from three clinical teams about their alignment to the Enhanced Care Integrated Team (ECIT) proof of concept principles/themes

Principles/Themes	Service/Team response		
Service/team provision	Team A Urgent Community Response – 2 hour response to referrals from the community or A & E Rapid Response and Care – Support people for up to 6 weeks	Team B Home Independence– Reablement support for up to 6 weeks	Team C Home First – Provision of care to patients at home for up to 28 days
Team provides earlier access to multiprofessional, coordinated care for patients	✓	✓	✓
Service provided by the team is proactive care model	✓ where possible	✓ where possible	✓ where possible
Service provided by the team is based on evidence derived from models such as enhanced supportive care, and enhanced health in care homes (set out in table 1) .	partially	partially	partially
Team demonstrates integrated care by having staff from both social care and health	X There is work undertaken across teams to support patients	x There is work undertaken across teams to support patients	x There is work undertaken across teams to support patients
Team demonstrates the use of technology to improve communication	✓ To an extent	✓ To an extent	✓ To an extent
Co-production and collaboration with people with lived experience demonstrated.	✓ In the form of feedback surveys	✓ In the form of feedback surveys	✓ In the form of feedback surveys
Personalised care demonstrated.	✓	✓	✓
The team is linked into the Transfer of care hub	✓	✓	✓
The team is integrated into the local Neighbourhood Health Teams	In progress	x	In progress
Service/team staffing			
Rehabilitation/therapy assistants	✓	x	X

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Enhanced care workers	x	x	X
Occupational therapists	✓	X Work closely with OTs in social care	✓
Paramedics	✓	x	x
Physiotherapists	✓	x	✓
Dietitians	x	x	x
Speech and language therapists	x	x	x
Social workers	x	✓	✓
Nurses	✓	x	✓
Other: Please specify	✓ Healthcare assistants	✓ Social care assistants, social work assistants	✓ Clinical support workers
The team is multiprofessional.	✓	✓	✓
The team is led by Allied Health Professionals from either social care or health.	Led by AHP in health	Led by a registered manager in social care	Led by a social worker in health
The team includes staff who work in: a) Social care b) Acute care c) Community services d) Primary care	Acute Trust employed staff only	Local authority employed staff only	Acute Trust employed staff only
The team identifies staff working at different levels of practice			
Supportive/assistive	✓	✓	✓
Registered	✓	✓	✓
Enhanced practice	x	x	x
Advanced practice	x	x	x
Consultant practice	x	x	x

Table A3 - Findings from three clinical teams about their alignment to the ALIGNS career development and education development framework proof of concept principles/themes

Principles/themes	Service/Team response		
	Team A Urgent Community Response – 2 hour response to referrals from the community or A & E Rapid Response and Care – Support people for up to 6 weeks	Team B Home Independence Team – Reablement support for up to 6 weeks	Team C Home First – Provision of care to patients at home for up to 28 days
A <u>uniprofessional</u> competence and capability framework exists that is used to support staff development	✓ Different competence documents for different staff	✓ Different competence documents for different staff	✓ Different competence documents for different staff
A <u>multiprofessional</u> competence and capability framework exists that is used to support staff development	x	x	x
Levels of practice of staff are used to inform and support staff development, education, training and career progression	x	x	x
Core capabilities are used to support development and progression of staff at all levels of practice (supportive, assistive, registered, enhanced, advanced, consultant)	✓ Levels of practice not necessarily used	✓ Levels of practice not necessarily used	✓ Levels of practice not necessarily used
Core capabilities included in any framework comprise those in each of the following categories:			
<ul style="list-style-type: none"> Person centred collaborative working 	✓	✓	✓
<ul style="list-style-type: none"> Assessment, investigations and diagnosis 	x	✓	✓
<ul style="list-style-type: none"> Condition management, treatment, clinical decision making and planning 	✓	✓	✓

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<ul style="list-style-type: none"> • Leadership and collaborative practice 	X	X	X
<ul style="list-style-type: none"> • Developing evidence-based practice and improving quality; Research 	X	X	X
<ul style="list-style-type: none"> • Developing evidence-based practice and improving quality; Service evaluation and quality improvement 	X	X	X
<ul style="list-style-type: none"> • Educating and developing self and others 	X	X	X
A multiprofessional education framework with a range of training and development opportunities is in place to support staff	No framework However range of training and development opportunities identified for staff	No framework However range of training and development opportunities identified for staff	No framework However range of training and development opportunities identified for staff
There are transparent, clear career pathways for staff.	To some degree	To some degree	To some degree

The findings and suggested next steps are in the main findings of the project report section 4.4.8.1

ANNEX 4: Strengthening the voice of Occupational Therapists in integration.

A conversation with a very senior medical ICS lead for frailty, palliative and end of life care, highlighted how important it is to strengthen the occupational therapy voice to enable greater integration between social care and health. With the support of strategic leaders from Kent and Medway ICS and Kent County Council a workshop was designed with the following objectives:

1. Workshop attendees will share their knowledge and expertise about their, and their wider stakeholders' perceptions of the roles of OTs in integration.
2. Describe assets that have been developed to describe the roles of OTs in integration.
3. Identify tangible assets that could be created to support strengthening the OT voice in integration.
4. Work towards an output(s) that results in clear information about the OTs role in integration for non-OT professionals.

The detail provided in this section adds to the information provided in section 4.5.5 Strengthening the voice of Occupational Therapists in integration – the workshops.

Eighty registered to attend one of the two identical workshops with the following agenda:

Table A4 - Strengthening the OT voice in integration workshop agenda

Tine allocated (mins)	Activity	Lead
10	Welcome, workshop aims and objectives	June Davis, Co-Director, Allied Health Solutions and ALIGNS programme team member
10	Overview of the ALIGNS programme	Professor Mary Lovegrove OBE, Co-Director Allied Health Solutions and ALIGNS programme lead
	Royal College of Occupational Therapy workforce strategy	Lauren Walker, Professional Advisor, Royal College of Occupational Therapy
5	What does integration mean for you?	Slido activity
5	Rationale for workshop	Aparna Belapurkar, Chief AHP, CMO Directorate, Kent and Medway ICB
20	Breakout group 1 1. What do occupational therapists say about how they enable integration? 2. What do occupational therapists tell others e.g. Doctors/nurses/other allied health professionals about their role in integration? Capture any good practice in relation to the OT voice in integration	Facilitators

20	Breakout group 1 feedback	Facilitators
10	Short break	
20	Breakout group 2 Discuss and identify: <ul style="list-style-type: none"> • Current resources that are available linked to strengthening the OT voice in integration • Potential resources that could be developed to strengthen the OT voice in integration? 	Facilitators
10	Breakout group 2 feedback	Facilitators
5	Your pledge What is one thing you could do in your day to day work to strengthen the OT voice in integration?	Slido activity
5	Next steps	June Davis, Co-Director, Allied Health Solutions and ALIGNS programme team member

The Royal College of Occupational Therapists presented the RCOT workforce survey 2023 report and reported how the RCOT developed its’ strategy and shared the following information:

OTs and AHPs are essential to a successful and sustainable health and care system.

There aren’t currently enough OTs and AHPs to meet demand, and demand is increasing.

The unique skills of OTs and their AHP colleagues aren’t always deployed in the most effective way, in the best place, or at the right time.

The workshop participants engaged in the Slido question 1: What does integration mean to you? The consensus from both workshops was collaboration and working together (figure A1)

The focus of breakout session 1 was:

1. What do occupational therapists say about how they enable integration?
2. What do occupational therapists tell others e.g. doctors/nurses/other allied health professionals about their role in integration?
3. Capture any good practice in relation to the OT voice in integration

The collation of the comments about **what OTs say about how they enable integration** are grouped under:

- ◆ Discussions about integration (Box A2)
- ◆ Why OTs are central to integration (Box A3)
- ◆ Where to start (Box A4)

Box A2: Discussions about integration

Experience of integration is very varied:

- ◆ Integration isn't being discussed in the acute sector, and for some, integration is at an all time low.
- ◆ Integration only being discussed amongst senior AHP leaders.
- ◆ Talking about integration all the time. 2024 – workforce review of OT and physio. Lots of meetings with AHPs and care group directorate. Looking at vision. What should be done. Prevention and integration.
- ◆ Term not used but is happening in practice.
- ◆ Lots happening

Box A3: Why OTs are central to integration

- ◆ OTs understand different models of care - **we are a good bridge. Dual trained is a superpower which makes it easy to deploy the bridge.**
- ◆ An OT is a service user's best friend
 - A force for enabling people
 - Person centred
 - Problem solvers
 - Have a variety of tools available.
- ◆ OTs go into homes/hospitals/care homes
- ◆ OTs connect with social care and vice versa
- ◆ OTs in general are naturally good at reaching out and making links with different services.

Box A4: Where to start

- ◆ Start with pre-registration students
- ◆ Learners need to know about structure of system.
- ◆ Strategic- set a core expectation about integration
- ◆ Work much more closely together across the systems
- ◆ Can we be more creative and take more risks?

The collation of the comments about **What do occupational therapists tell others e.g. doctors/nurses/other allied health professionals about their role in integration** are grouped under:

- ◆ Lacking in confidence (Box A5)
- ◆ Workforce structures that limit integration (Box A6)
- ◆ Groups that OTs aim to influence (Box A7)
- ◆ Challenges to effective integration (Box A8)
- ◆ Information shared about OTs (Box A9)

Box A5: Lacking in confidence

- ◆ OTs struggle to articulate their worth.
- ◆ Need to be braver about conversations.
- ◆ Get resistance from other groups.
- ◆ OTs assume that people know what they do.
- ◆ Feel like the poor relative to other professions.
- ◆ OTs are not good at explaining what they do. They find it easier to demonstrate.

Box A6: Workforce structures that limit integration

- ◆ No AHP Director to raise the profile and make a difference.
- ◆ A junior workforce
- ◆ Leadership is an issue - not many senior OT posts.
- ◆ In some trusts no OTs employed above Band 8a.
- ◆ OTs can be integrated but the organisational/leadership structures do not support this.

Box A7: Groups that OTs aim to influence

- ◆ Medical students
- ◆ Multidisciplinary Teams
- ◆ Nurses
- ◆ Physiotherapists
- ◆ Social Workers
- ◆ HEI staff

Box A8: Challenges to effective integration

- ◆ Everybody is overstretched.
- ◆ Social Workers do not always understand the difference between what OTs in health do and what those in social care do.
- ◆ IT systems that are not compatible.

Box A9: Information shared about OTs

- ◆ Celebrate OT strengths and differences, their practical skills, a holistic approach, good at problem solving.
- ◆ OTs are very obliging and probably take on too much.
- ◆ Enabling people to do things for themselves. Knowledge across health and social care is gold dust.
- ◆ Focus on functional role and difference between OT and physiotherapy.
- ◆ Weekly conference calls, lots of shared patients. Ensuring the patient will be seen

Examples of good practice of OTs leading integration that were shared by the workshop participants are grouped under:

- ◆ Clinical experience (Box A10)
- ◆ System opportunities (Box A11)
- ◆ Focussed meetings (Box A12)

Box A10: Clinical experience

- ◆ SPRINT – shadowing opportunities in Kent, where OTs can spend two weeks with another team.
- ◆ In Oxfordshire many of the OTs have worked in Social Care and the access to health is seamless.
- ◆ There is a rotational Band 5 offer: children’s services, mental health services; community; LAs.
- ◆ Student opportunities e.g. social care and NHS placements on OT programme (Brighton University).
- ◆ Falls Frailty Response – OT goes out with paramedic to prevent admission
- ◆ OTs and social workers are integrated.
- ◆ Rehabilitation workers on joint contracts, they are paving the way for integration.

Box A11: System opportunities

- ◆ Work together on moving and handling.
- ◆ Advocacy and integration across ICB.
- ◆ Currently working on a business case for OT role supporting patients with drug and alcohol-acquired brain injuries this requires a lot of cross-agency collaboration.
- ◆ Better Care Fund is for both health and social care.
- ◆ All providers are on system 1 and staff are able to see all the records and have integrated services: health, social care and rehab assistants.
- ◆ Good reablement and Home First systems.
- ◆ There are no psychologists in the Trust so OTs are demonstrating how they can support patients with complex physical and mental health co-morbidities.
- ◆ Focus on D2A pathways, and myriad of services (East Kent), referral criteria etc.

Box A12: Focussed meetings

- ◆ Periodic meetings between health and social care at Band 7 level
- ◆ workshop with social workers about role/professional identity.
- ◆ Integration workshops: acute, community, social care, mental health.

During breakout session 2 the participants were asked to consider what **existing resources are available linked to strengthening the OT voice in integration and what are the potential resources that could be developed to strengthen the OT voice in integration?** The existing resources they suggested have been grouped under the following headings:

- ◆ People (Box A13)
- ◆ Events (Box A14)
- ◆ Tools (Box A15)
- ◆ Potential activities (Box A16)

Box A13: People

Existing people	Potential people
<ul style="list-style-type: none">◆ Pre-reg students on placement to pilot innovations◆ Student project on therapy gardens.◆ Educating the learners◆ Review pre-reg curricular◆ PCN networks◆ Communities of Practice◆ Shadowing opportunities◆ Joint preceptorship programmes◆ CPD opportunities◆ OT networks	<ul style="list-style-type: none">◆ Unregulated workforce◆ Pre-registration students' exposure to social care◆ Visible OT leaders◆ AHP faculties◆ Ongoing education of colleagues

Box A14: Events

Existing events	Potential events
<ul style="list-style-type: none">◆ Sandwich making workshop◆ AHP faculty meetings◆ Workforce development meetings◆ Meetings with HEIs◆ ICB AHP days – celebrating and showcasing practice to other AHPs	<ul style="list-style-type: none">◆ Webinars e.g.. integration and leadership◆ More training and discussions like this.◆ Conferences e.g. Community Care, OT Show

Box A15: Tools

Existing tools	Potential tools
<ul style="list-style-type: none">◆ Videos e.g. Hampshire & Isle of Wight road map with a series of videos around what OTs do.◆ Sharing papers e.g. risk assessment, single assessment records.◆ Storing documents on a shared platform very difficult.◆ WhatsApp group for single handed care.◆ Facebook site◆ RCOT resources<ul style="list-style-type: none">● Can you lead and shape your community? - RCOT● Reimagining communities - RCOT● Innovation Hub - RCOT● Supporting OT Week 2024 - RCOT● Raising the profile of occupational therapy - RCOT◆ Advertising in community spaces/waiting areas.	<ul style="list-style-type: none">◆ In-service training resources◆ Outcome measures for use in primary care and other parts of the continuum of care◆ International resources e.g. Australia, Canada◆ Examples of best practice – case studies to inspire

Box A16: Potential activities

<ul style="list-style-type: none">◆ Need to consider what level to have discussions i.e. nationally, regionally, ICB, service level.◆ Workforce development roles focused on integration.◆ Opportunity to share and learn with colleagues.◆ Research and quality improvement skills for OTs
--

At the close of the workshop the participants were asked to pledge **one thing they could do, in their day to day work, to strengthen the OT voice in integration** They recommended better communication, enhanced leadership, develop relationships, enable rotations, review work practices and share with others.

One thing to strengthen OT voice

Communication

- Ask for feedback
- More open conversations and prioritise these
- Discuss it regularly with own team to promote and embed in practice
- Be vocal about why OT is beneficial to people and services.
- Communicate effectively
- Keep saying the word integration in sentences so it becomes part of the conversation
- Keep integration high on the agenda in conversations with all colleagues
- Pick up the phone rather than sending an email
- Explicitly state the OT contribution in all work
- Talk about what we do
- Shout about the great work at every opportunity
- Talk about the different services
- Keep talking
- Continue to encourage the debate
- Ask if they've consulted OT

Leadership

- Advocate for OTs as leaders for the remainder of university apprenticeship programme and into employment as a Band 5
- Develop OT leaders
- Practice inclusive leadership and ensure representative voice across the AHP Faculty

Relationships

- Network
- Build relationships
- Liaise with our AHPs involved in a person's care
- Think wider

Rotations

- Rotations and upskilling opportunities
- Rotations with social care
- To identify OTs within generic integration work role.

Work practices

- Set clearer boundaries on the OT role
- Identify priorities and impact and turn into action
- Prioritise meetings that promote integration
- Just do the small things- rather than wait for huge, tailored projects
- Really understand patient pathways
- Champion working together.

Sharing with others

- Share examples of good practice with others
- Use any opportunity to share what we do
- Capture and share impact and outcome data about what OT is achieving for people and systems

ANNEX 5: Current (2024/25) Care Quality Commission inspection outcomes for local authorities in the South East

Table A5 – Quality and learning improvement CQC comments for LAs in South East 2024/2025

Local/Unitary Authority	Date of report	Quality score	Quality statement	Learning, Improvement and Innovation Score	Learning, Improvement and Innovation Statement	Comment from CQC report
Bracknell Forest	2024	64	Good	3	Evidence shows a good standard	<i>Coproduction was embedded throughout the local authority's work</i>
Buckinghamshire	2025	73	Good	3	Evidence shows a good standard	<i>Staff and leaders told us about a grow your own approach in the local authority which was linked to the health and social care academy and staff's opportunities to access continuous professional development and an extensive training offer. The local authority worked collaboratively with people and partners to promote and support innovative and new ways of working aimed at improving people's social care experiences and outcomes such as independence and well-being.</i>
Kent	2025	56	Requires Improvement	3	Evidence shows a good standard	<i>The PSW and Principal Occupational Therapist worked well together and facilitated regular supervisions, audits, and shared learning opportunities within the department for all staff. Both roles oversaw quality assurance and improvement of practice. KCC worked collaboratively with people and partners to actively promote and support innovative and new ways of working which improved people's social care experiences and outcomes.</i>
Medway	2025	59	Requires Improvement	2	Evidence shows some shortfalls	<i>The local authority needed to do more work in collaborating with people and partners to actively promote new ways of working which improved people's social care experiences and outcomes.</i>
Royal Borough of Windsor and Maidenhead	2024	62	Requires Improvement	2	Evidence shows some shortfalls	<i>The local authority was undertaking a significant transformation which was informed by learning. Staff and leaders could clearly articulate what the local authority did well as well as an honest appraisal of where they needed to improve.</i>

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Surrey	2024	70	Good	3	Evidence shows a good standard	<i>Almost unanimously staff fed back they were proud to work in Surrey feeling they made a positive difference to people's lives through the work they did. An academy had been developed which was headed by the Principal Occupational Therapist. They had expanded the opportunities to provide continuous learning for career progression, these included opportunities to become a qualified occupational therapist, or</i>
West Berkshire	2024	65	Good	3	Evidence shows a good standard	<i>Staff told us there was an inclusive and positive culture of continuous learning and improvement. The local authority needed to do more work in collaboration with people and partners to promote and support innovative and new ways of working to improve people's social care experience and outcomes.</i>
West Sussex	2025	67	Good	3	Evidence shows a good standard	<i>The local authority had a clear focus on staff growth, with measures in place to support performance improvement. We heard teams were encouraged to share knowledge through joint team meetings and were provided opportunities to work within different teams to strengthen and expand upon their knowledge.</i>
Wokingham	2025	81	Good	4	Evidence shows Exceptional Standard	<i>There was a positive culture of continuous learning and improvement in the local authority. The recent addition of the Principal Occupational Therapist supported the ongoing development and identity of therapy services in the borough as integral to the delivery of Care Act duties. The local authority told us that the Quality Assurance Framework was equally applied to audits and reviews of occupational therapists' work as social work practice. The newly recruited Principal Occupational Therapist was developing specialised audits to strengthen processes further.</i>

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Enterprise Innovation Partnership