Allied Health Solutions

Enterprise Innovation Partnership

The ALIGNS programme

(AHPs Leading InteGration betweeN Social Care and Health)

End of project report

Buckinghamshire Health & Social Care Academy

‘Enable us to say it once’.

The service users and their carers requested that the staff, across the sector, find a way to integrate the services, so those with lived experience are not required to repeat again and again the same information about their clinical condition and personal circumstances.

‘We know that OTs are central to effective integration between social care and health, but we are not clear what they do.’

ICB Clinical Lead

Allied Health Solutions (AHS) in partnership with Buckinghamshire Health and Social Care Academy (BHSCA) delivered this ALIGNS programme, supported by NHS England (NHSE) South East Workforce, Training and Education Directorate.

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Particular thanks go to the Project Oversight Group members, who guided this work for the duration of the project, and Elizabeth Evans, AHP Workforce Programme Fellow, who worked with us to deliver this programme.

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1.0 The introduction

This report is the final output of ALIGNS (**A**HPs **L**eading **I**nte**G**ration betwee**N** **S**ocial Care and Health), an eighteen-month project, commissioned by NHS England (NHSE) South East Workforce, Training and Education Directorate.

The objective of the project was to support the Allied Health Professionals (AHPs) in the South East of England to lead on strengthening the integration between Social Care and Health services, for the benefit of the community they serve.

1.1. Background to the project

In 2023 NHSE published information and resources to support the AHP integration agenda[1]. The primary driver for developing this resource was to **value and support the AHP social care workforce as vital contributors to the integration agenda**. Four dimensions were identified:

1. Integrated AHP workforce data
2. Leadership and Architecture for social care
3. Attracting and recruiting the AHP social care workforce
4. Collaborative learning, development and workforce initiatives.

Also recognised in this resource was the importance of the different social care and health culture and climate, in which AHPs work.

1.2. About the project

The ALIGNS project aimed to gain an in-depth understanding of the level of maturity, of the six South East regional Integrated Care Systems (ICS), for each of the dimensions. It also aimed to capture examples of best practice that support integration.

At the beginning of the project it was decided that the **focus of ALIGNS** would be a) on occupational therapy teams working in adult care, and b) through the lens of social care. It was also agreed that the level of maturity of a fifth dimension: culture, climate and ways of working together, for each ICS, would be determined.

1.3. Structure of the report

Sections two and three cover the context of the work and the approach to ALIGNS. Section four of this report records the detail of the six ICB's (Integrated Care Boards) self-reported level of maturity for the five dimensions of the AHP integration agenda, including examples of best practice, ALIGNS bespoke developments at three case study sites, and the outputs from the Strengthening the voice of Occupational Therapists in integration workshops. Some of the information is supplemented with further detail in five annexes collated in a separate document. General discussion, conclusion and recommendations are covered in section five.

2.0 Context

Section 3 of The Care Act (2014)[2] for England and Wales: **Promoting integration of care and support with health services…** states:

'A local authority (LA) must exercise its functions with a view to ***ensuring the integration of care and support provision with health provision and health-related provision.*** *It goes on to note an LA must:*

a) *promote the well-being of adults with care and support needs and the well-being of carers;*
b) *contribute to the prevention or delay of the development by adults with care and support needs or carers with support needs;*
c) *improve the quality of care and support for adults, and support for carers.'*

Social workers make up the majority of the social care workforce. In the UK, there are significantly more registered social workers than registered occupational therapists (OTs). In March 2025 Social Work England[3] reported 13,051, out of 104,857 registered social workers, are employed in the South East. From this data it has been estimated that approximately 4000 work in adult social care in the South East of England. In comparison, The HCPC data states that as of August 2025 there are 48,091 registered OTs of which according to Skills for Care 2024[4] data, 3,400 are employed in local authorities (for the structure of local authorities/unitary authorities in the South East of England see figure 1). July 2025 data provided by NHSE WTE South East states that 600 of these OTs work in adult social care in the South East. This results in a ratio of 1 OT for every 6.7 social workers.

In 2021 the Royal College of Occupational Therapists (RCOT) published a resource[5] that provided guidance for principal occupational therapists (POTs), and social care leaders, who wish to develop this post within existing services. In 2024 the RCOT published their Workforce Strategy[6] with a clear commitment to optimising the impact of occupational therapy and supporting '*occupational therapy practitioners to be changemakers* and use their *skills and knowledge ..to improve people's lives and wellbeing'* (figure 2).

In June 2024 the Directors of Adult Social Services for the East and West Midlands published a report about optimising occupational therapy as a high-impact resource[7]. They advocated for a 'therapy-led approach' in social care and argued that the unique contribution OTs make in social care actively prevents, reduces or delays the requirement for further social care provision and optimises strength-based care.

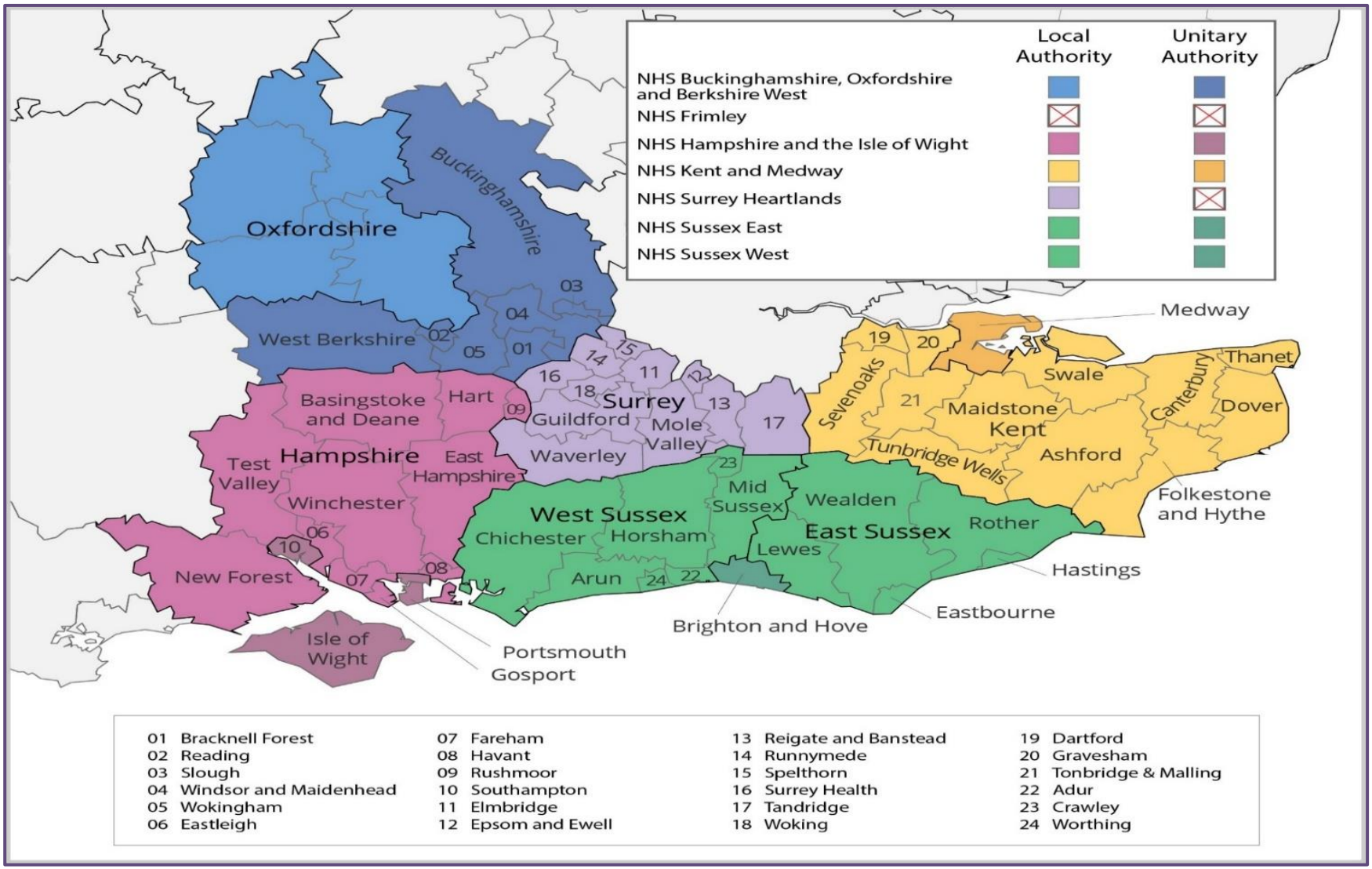


Figure 1: Local and Unitary Authorities in the South East of England

(NB: Frimley Health and Care ICS (Integrated Care System) is covered by Surrey Heath Borough Council)

Figure 2: Positioning Occupational Therapy for the future

In 2025 the Local Government Association (LGA) published a report entitled: Occupational therapists in councils: Unlocking capacity and driving change[8]. The authors had three asks of the government one of which was to *Unlock OT potential* and to *Take specific actions to realise the potential of OTs in councils, enabling them to contribute more effectively to the health and care system in both the short and longer term*.

One of the key recommendations from this LGA research was for the government to **recognise the value of occupational therapy** (Box A). Specific recommendations included five recommendations for Health and Care Partners, two of which relate to integration (Box B).

Box A: Recognise the value of Occupational Therapy

'Occupational therapists play a vital role in preventing, delaying, and reducing the need for care and support, contributing significantly to positive outcomes for individuals, communities, and neighbourhoods. OTs support Care Act duties and enable better outcomes through prevention and person-centred care. Their work supports the delivery of local authority statutory duties and health and social care reform. Embedding an OT adviser with responsibility for local authorities in the Department of Health and Social Care would further promote OT leadership and practice and encourage a stronger shift towards prevention across councils.'

Box B: Recommendations for health and care partners

Foster collaboration between councils, the NHS, and the voluntary sector and promote OT leadership

'Partnerships are essential to optimising the contribution of OTs and reducing duplication of effort. Joint frameworks would enable professionals to work seamlessly across organisational boundaries.'

Promote OT leadership

'Health partners should ensure that OTs are included in strategic decision-making and leadership roles within integrated care systems. This would support more effective collaboration and improve service delivery across sectors and support delivery of system clinical and care professional leadership ambitions.'

The researchers also highlighted examples of councils optimising the contribution OTs make to the care of their residents (Box C).

In 2019 the RCOT published a report[9] about the value of occupational therapy in social care. As shown in figure 3, OTs provide three levels of service: Universal, targeted, specialist.

More recently (2025) the NHS published a10 Year Health Plan for England[10] (Fit for the Future) which sets out three proposed major transformational healthcare shifts:

1. From Hospital to Community
2. From Analogue to Digital
3. From Sickness to Prevention

These three shifts form the components of a new care model and increase the opportunities for integration. Integration between social care and health is key to the success of the shift from Hospital to Community and the Plan states DHSC (Department of Health and Social Care) will reform the Better Care Fund and focus joint funding on those services which are essential to effective integrated care. The intended shift from analogue to digital should reduce the reliance

on IT systems that do not allow for transfer of patient data, which will in the future be held by the patient and their carers and align with the wish to only '**say it once'**.

Box C: Best practice for local authorities

Recognise the value of occupational therapy

'OTs are essential in delivering preventative care and improving outcomes for communities. Councils should fully utilise their contributions to reduce pressures on health and care systems and achieve statutory responsibilities under the Care Act.'

Promote OT leadership

'Principal OTs should be positioned within senior leadership teams, with appropriate seniority and visibility to optimise influence and impact. Working alongside PSWs and Assistant Directors within councils, contributing to strategic decision-making and enhancing local service delivery. Their expertise can help bridge gaps between health and social care systems and deliver on Care Act duties, particularly (but not exclusively) in relation to prevention.'

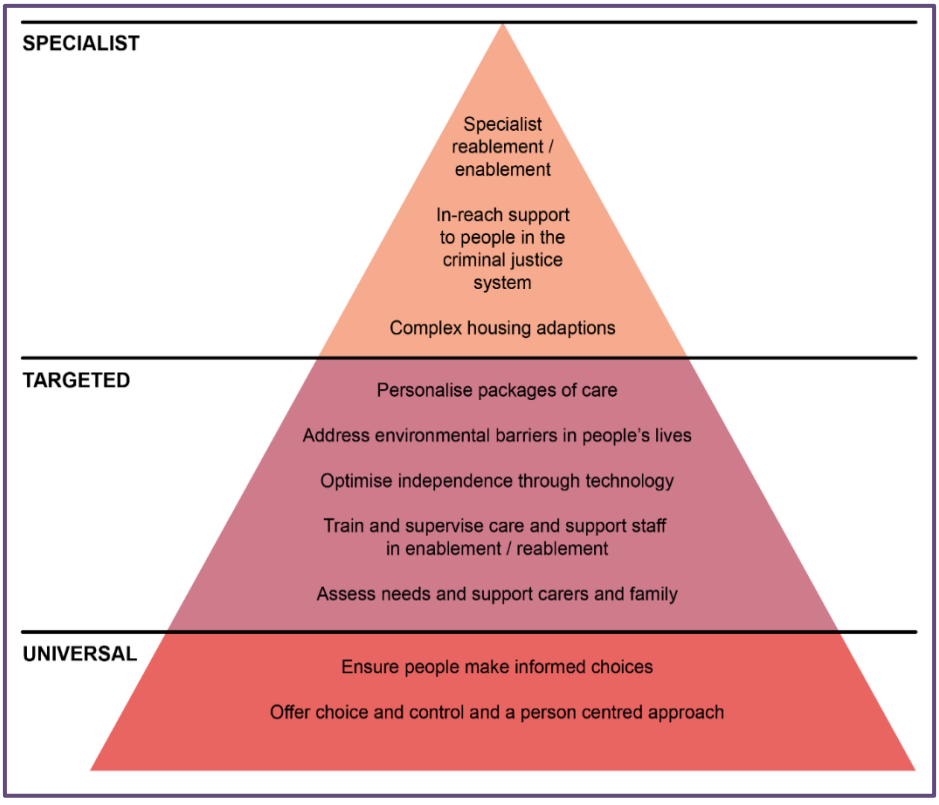


Figure 3: Occupational therapy in social care – levels of service

Between 2021 and 2023 NHS England carried out three projects about AHPs supporting integration:

a. Allied Health Professional (AHP) Leadership in local authorities[11]
b. AHP workforce in social care. Optimising collaboration and integration[12]
c. AHPs leading integration 2022-2023[1]

In 2024 Skills for Care (SfC) published a new workforce strategy for Adult Social Care in England[13]. One of the three priorities in this report was to **transform** the approach to the workforce to meet the changing needs of the population. In this report SfC recommended mandating workforce planning and strategy; investigating workforce registration; improving referral routes and assessment times.

In May 2025 SfC launched the 'Enhanced care worker' role category[14]. This category of worker applies to those who assist people who need care and support to be able to live their lives. The support provided may be person-centred or condition specific specialist support.

The recently published Allied Health Professions (AHP) Research Priorities[15] listed four priorities that relate directly to ALIGNS:

1. Identify and evaluate **digital tools and data-driven approaches** in AHP practice to enhance patient care, outcomes and access to services.
2. Impact of AHPs in **patient flow, discharge planning and service effectiveness** including health outcomes, admissions, length of stay, waiting lists and supporting safer transition home.
3. Identifying where AHPs have the best potential to improve patient care, experience and outcomes **(whole patient pathway and lifespan)**.
4. Impact of AHPs in **optimising rehabilitation and reablement** including improving occupational health, employment and community recovery outcome.

3.0 The approach to ALIGNS

At the outset a **Project Oversight Group** (POG), chaired by NHSE South East Senior AHP workforce and education specialist: Integration, was established (appendix 1). Initially the POG met monthly; towards the end of the study, the meeting frequency was reduced to every two months. All major decisions about the project were taken by the POG.

An **Expert Reference Group** (ERG), which met four times during the project, was convened to provide advice and professional guidance to the ALIGNS delivery team. Membership of the ERG (appendix 2) reflected the broad scope of AHP social care and health services for adults.

The project governance is shown in figure 4.

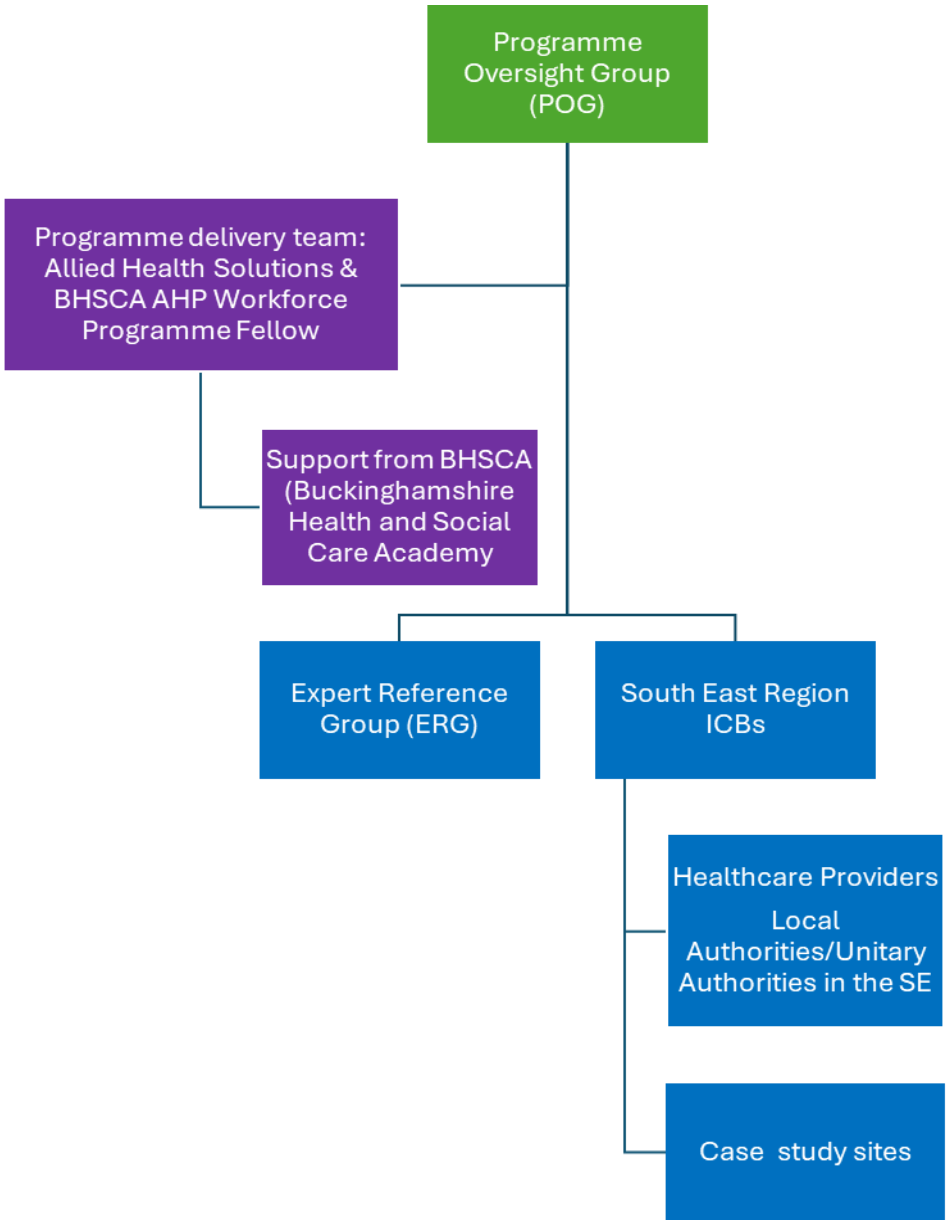


Figure 4: ALIGNS governance structure

The ALIGNS project has been delivered in three parts:

- Ascertaining how each of the six ICSs[a] in the South East (figure1) are performing against the AHPs Supporting Integration Framework dimensions.
- Establishing three case study sites (Buckinghamshire; Berkshire West and Frimley [formally known as Frimley Health and Care]; Kent and Medway) to gather detailed information about current integration and explore potential opportunities for further integration.
- Holding two online workshops on **Strengthening the voice of Occupational Therapists in integration**.

To illustrate the complexity of ALIGNS an implementation model was designed (figure 6).

3.1 The four levels of maturity

The AHPs Supporting Integration Framework sets out three levels of maturity: emerging, developing and maturing. A recent report[7] recommended adding a fourth level of maturity (pre-emerging). ALIGNS includes the four levels of maturity (figure 5) and table 1.

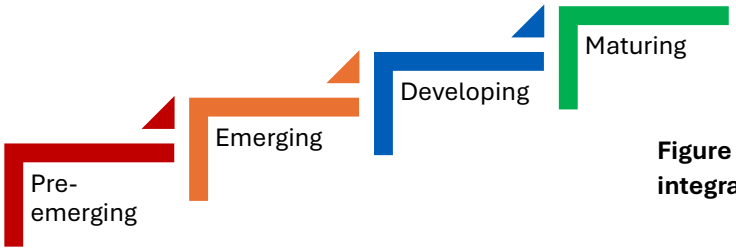


Figure 5: ALIGNS four levels of integration maturity

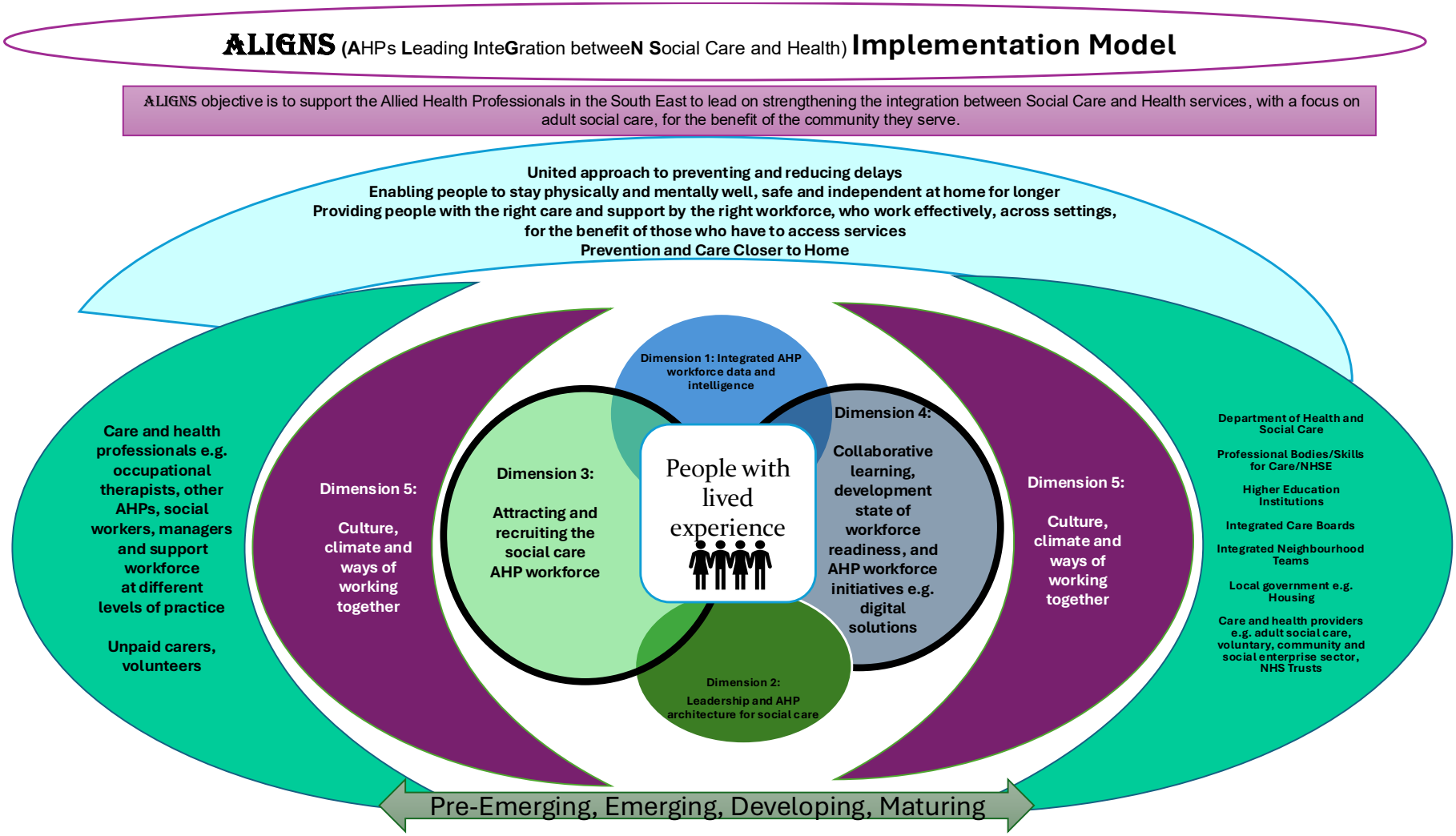
Table 1: Explanation of the four levels of maturity

Pre-emerging	Emerging	Developing	Maturing
Health and social care AHPs are working separately and areas for developing integrated ways of working are yet to be identified.	Health and social care AHPs are currently working relatively separately but starting to identify areas for developing integrated ways of working.	Health and social care AHPs are working mostly in separation, but there are tangible shifts towards integrated working in particular facets of workforce development.	AHPs across health and social care are working seamlessly as 'one workforce' at place-based, system and regional level; working together to navigate workforce challenges and provide cohesive delivery of services.

Each ICS was invited to self-assess their level of maturity for each activity identified in the framework. These activities were supplemented, where appropriate, with additional evidence.

[a] BOB (Buckinghamshire, Oxfordshire and Berkshire West); Frimley; Hampshire and Isle of Wight (H&IoW); Kent and Medway; Surrey Heartlands; Sussex

Figure 6: ALIGNS implementation model



4.0 Main findings

The main findings from the ALIGNS project are drawn primarily from the three data sources referred to in section 3:

- ICS self-rated performance against the five dimensions of the AHPs Supporting Integration Framework
- Case study sites' projects
- Two Regional workshops

ICS self-rated performance against the five dimensions of the AHPs Supporting Integration Framework

This section is set out according to the five dimensions in the AHPs Supporting Integration Framework:

4.1. Dimension 1: Integrated AHP workforce data and intelligence

The findings for Dimension 1 of the AHPs Supporting Integration Framework[1] are divided into two main sections:

4.1.1. Population health needs

According to NHS England, '*Population health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, while reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill health and to address wider determinants of health, and requires working with communities and partner agencies. Health staff need to feel confident in their skills and abilities to carry out their duties through existing roles, new roles and transformed services, to most effectively meet the health needs of their population*'[16].

The focus of ALIGNS was older adults.

The current data about South East ICS population size and the percentage who are over 65 is shown in table 2. For each of these systems the key population health needs are listed in table 3.

Table 2: Population size and percentage over 65 years of age by Integrated Care Systems

ICS	Population size	Percentage of population over 65 years of age	Source of data
Buckinghamshire, Oxfordshire, Berkshire West (BOB)	2M	20	integrated-care-strategy.pdf
Frimley Health and Care	800,000	15	Frimley ICS Strategy Refresh - March 2023
Hampshire & Isle of Wight (H&IoW)	1.9M	Hampshire 22 Isle of Wight 33	Making health and social care in Portsmouth better - Health & Care Portsmouth
Kent and Medway	1.9M	Kent 20.5 Medway 16	Kent and Medway Integrated Care Strategy
Surrey Heartlands	1.9M	19.1	Surrey Heartlands Integrated Care Strategy[17]
Sussex	1.9M	East Sussex 26 West Sussex 23.3 Brighton & Hove 13.6	0438 NHS Sussex VF4 4

Table 3: Significant population health needs by ICS in the South East

ICS	Significant population health needs
Buckinghamshire, Oxfordshire, Berkshire West	• The number of people aged over 65 is expected to increase by 11% over the next 5 years and up to 37% by 2042. • The BOB population is suffering with more long-term conditions: more than one in four of the adult population live with more than two long term conditions. • People with multiple conditions are more likely to have poorer health[18].
Frimley Health and Care	One of the key areas of focus is major health conditions, including cancer, stroke, cardiovascular disease, diabetes, and respiratory illness[19].
Hampshire & Isle of Wight	More deprived areas see higher levels of heart disease, diabetes, chronic obstructive pulmonary disease and mental health issues. People living in these areas are also more likely to experience not just one, but multiple ongoing health conditions[20]. Outcomes and activity indicate that focusing on cardiovascular disease prevention and proactive care for older people are priorities for the whole health system.
Kent and Medway	The health needs of this population will grow significantly up to 2043, with a higher number and proportion of the population with multiple and complex needs: • Between 2022 and 2027 frailty (severe) will increase by about 16.3%[21].
Surrey	Priorities for Surrey are: Vascular (Coronary Heart Disease, Hypertension, Stroke); Dementia; Diabetes; Osteoporosis and Arthritis[17].

Sussex	The common causes across all the Sussex populations are: • Respiratory problems • Mental health problems • Lower backpain and joint problems • Cardiovascular disease[22]

The occupational therapy teams provided very little information about the population health needs data. Under the **pre-emerging** level of maturity, Frimley reported that it uses Connected Care[b] which analyses population health to support service development. '*It is not known if this data has been used to support training and development needs'*. Surrey reported that although population health data is available, unfortunately it is not connected to AHP workforce. Hampshire and the Isle of Wight (H&IoW) noted that '*the local authorities are in the process of gaining access to skills for care data'*.

Under the **developing** level of maturity, H&IoW reported that '*population health, future projected needs as well as education, training and development opportunities are discussed at the AHP Council and Faculty. This data is then used, through commissioning reviews and system transformation programmes, to maximise the AHP contribution in line with identified needs, which in turn informs future workforce projections and AHP education, training, and development'*.

4.1.2. Occupational therapy workforce data

The South East occupational therapy workforce data has been provided by the Interim Head of System Workforce Planning & Transformation Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board in collaboration with the workforce data team at NHS England Workforce, Training and Education team in the South East. As shown in figure 7 the data is the analysis of where the registered OT workforce (WTE) is employed by an Integrated Care System (ICS).

As the data has been taken from different data sources[23], at slightly different times, it should be used as a high-level view of the proportion of occupational therapy workforce in different settings, and **not** as an indication of precise numbers. However, the data highlights the low percentage of the occupational therapy workforce employed in ICS NHS Community services (range 15%-2%). It also illustrates 25%-16% are employed in social care. **Consequently, the OT workforce is not aligned to where people with complex needs require the expertise of this profession.**

In the autumn of each year Skills for Care (SfC) collect workforce data. The SfC 2024 OT employment data for each South East authority (published February 2025) is set out in annex 1. The data range response across the South East for each data field is shown in table 4. It is important to note that SfC data counts qualified OTs only as "OT". This data includes OTs but not Principal OTs and OT managers. NHS and Social care job role descriptors are reported differently e.g. someone listed as in a junior management post in adult social care would be included as an OT under NHS data. The SfC support workforce data does not identify specifically the OT assistant workforce.

[b] Connected Care is a healthcare delivery model that uses technology and data to improve population health outcomes by integrating care across multiple providers.

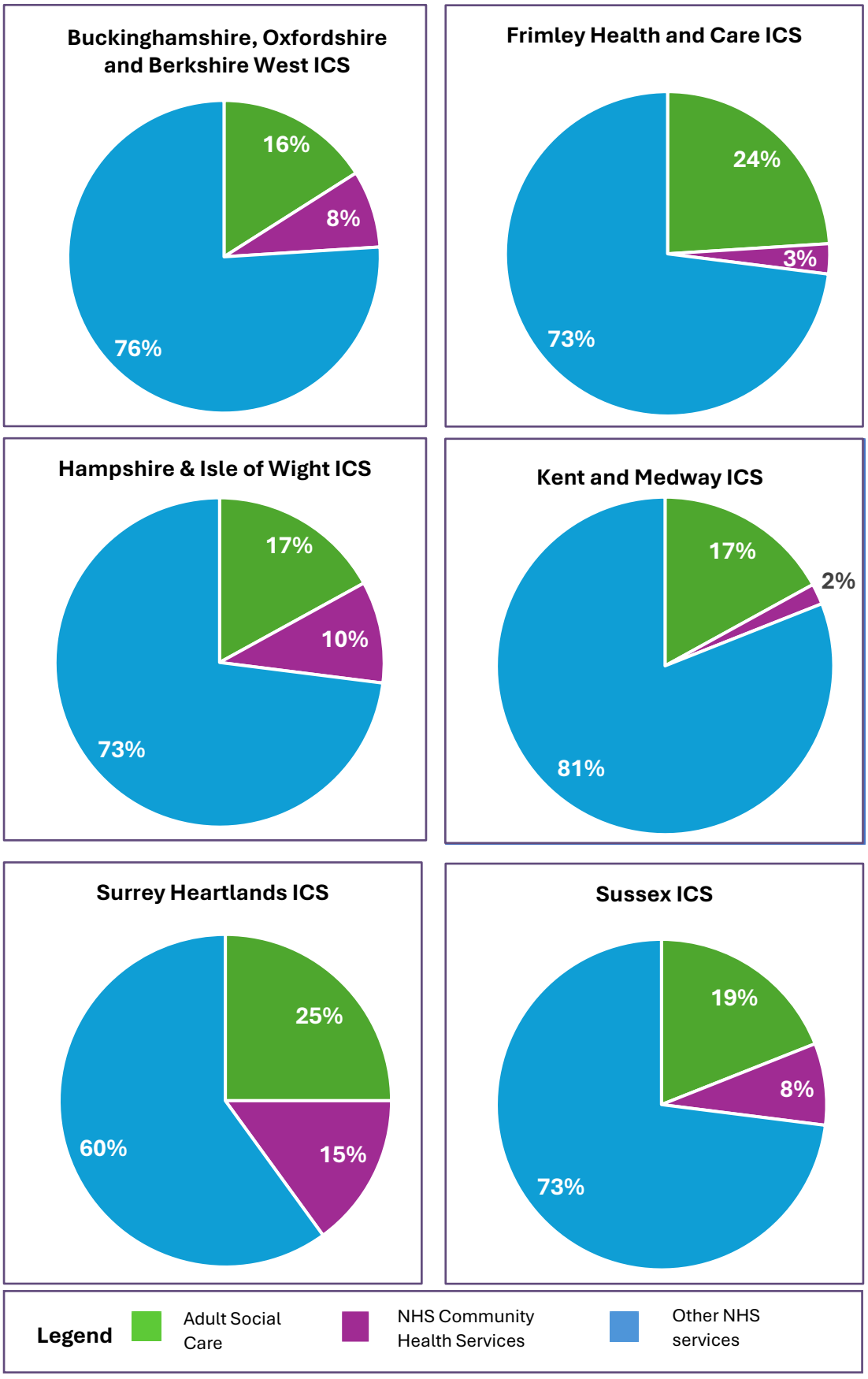


Figure 7: Where the OTs are employed in South East by ICS – 2025 data

Table 4: Skills for Care occupational therapy workforce data range - 2024 data

Data field		Range across the South East	
		Maximum	Minimum
Permanently employed (%)		100	67
Temporarily employed (%)		13	0
Indirectly employed (%)		27	0
Work full time (%)		91	40
Work part time (%)		60	9
FTE filled post ratio		0.98	0.72
Experience in the sector (average number of years)		12.5	4.8
Experience in role (average number of years in the role)		8.7	2.4
Gender (female %)		100	81
Ethnicity %	White	100	73
	Black/African/ Caribbean/Black British	19	0
	Asian/Asian British	6	0
	Mixed	9	0
	Other	1	0
Nationality %	British	100	78
	Non-EU	16	0
	EU	12	0
Age%	< 25	8	0
	25-54	90	65
	55 & >	34	10

The detailed South East ICS self-reported level of maturity about the workforce data is included in the section below. The headings have been taken from the AHPs supporting integration framework which is part of the wider AHPs leading integration framework.

4.1.2.1. Principal OTs /AHPs in local authorities (LAs) nominate someone to work alongside their LA data representative to ensure AHP workforce data is correct for input to the annual Skills for Care data set.

H&IoW reported this as **emerging** because most Principal OTs (POT[c])s can identify who in their organisation is responsible for the annual SfC data set. However, only one POT has input to ensure AHP workforce data is correct.

4.1.2.2. Ownership is taken by each POT in local authorities to input into the Skills for Care data set; directly aligning with the priorities of the Long-Term Workforce Plan

There is no evidence from ALIGNS that this is happening at any level of maturity

4.1.2.3. There is a clear understanding of the AHP workforce numbers, skills, capabilities, and levels of practice in social care

Under **emerging** Frimley recorded the concern about the accuracy of the SfC data. Many AHPs working in Social Care may not work under identifiable AHP role titles. It also doesn't include apprentices and is unable to differentiate if support workers are AHP specific.

[c] In this report the abbreviation POT includes all those who use the term Principal Occupational Therapist, Principal Lead Occupational Therapist or Principal Strategic Lead Occupational Therapist.

H&IoW noted comments under **emerging** and **developing** levels of maturity: they review data available through NHSE workforce intelligence portal that includes LA data. However, this information is limited, and the level of confidence in it is low. Nonetheless, all POTs feel that they have a clear understanding of the AHP workforce numbers, skills, capabilities, and levels of practice in social care.

4.1.2.4. AHP workforce data collected in LAs includes information on equality and diversity of the AHP workforce

Frimley and H&IoW reported under two levels of maturity:

Frimley advised under **emerging**, that in April 2025 the ICS started a workforce demand and capacity data programme. Under **developing**, equality and diversity for the AHP workforce was shared in the OT optioneering workshops. The next step is to report to AHP Board all sources of equality and diversity data.

> *'Data not always complete, quality needs improvement.'* Surrey Heartlands

Only one of the LAs in **H&IoW** (**pre-emerging**) confirmed that data includes information on equality and diversity of the AHP workforce. However, they reported (**developing**) great gains over the past year in terms of their understanding of AHP workforce data across health, and plan to apply these workforce projection models to the LA AHP workforce as part of the analysis of their last bi-annual workforce data return.

4.1.2.5. AHP workforce data from LAs and health is shared via the AHP councils and AHP faculties

The Surrey Heartlands AHP Council has just started to share data and in East Sussex there is no AHP Council. In East Sussex the data collected includes number of OTs and vacancies against a budget line.

> *'The AHP workforce data records the numbers but no insight into how the staff are developing as some of the staff are working at the top of their grade.'* East Sussex

4.1.2.6. AHP workforce data shared between LAs and health informs and shapes workforce planning in terms of designing, developing, and delivering the future AHP workforce across integrated systems

Hampshire County Council (**maturing**) has mapped their support workforce against the eight domains and competencies of the AHP support workers framework[24]. This mapping was shared across the ICS and used to inform the **H&IoW AHP Support Worker Strategy**[25].

4.1.2.7. Fully integrated AHP workforce data aligned with Electronic Staff Record (ESR)/NHS data and local authority data collection

H&IoW (**maturing**) LA AHP workforce data is captured as part of the bi-annual workforce data return and shared with the ICS Supply and Retention Board. They utilise the national capacity and demand tool and include LA AHP data in the analysis.

Frimley and H&IoW provided noteworthy additional information:

- Frimley (**developing**) optioneering workshops took place in Oct 23 and Feb 24 using the NHSE optioneering tool to look at NHS long term workforce plan; current data and different workforce models which would support meeting demand and agree a focus across the system. Key supply intervention areas were explored:
  - Undergraduate supply
  - International recruitment
  - Apprenticeships
  - Return to Practice
  - Retention.

  This was further reviewed with retention as a key focus and student supply both via undergraduate and apprenticeships route to continue to work at a system level.
- H&IoW (**maturing**) undertook an exercise to identify the OT vacancy and retention profile across the ICS. Following this they developed an OT roadmap and workforce strategy. They focused on:
  - Careers activity
  - Early recruitment through HEI open days
  - Band 6 retention
  - Exit interviews
  - Onboarding themes
  - Why OTs feel valued.

  LAs were included in the **'international recruitment collaborative'** and took part in developing and participating in the transition programme. H&IoW also delivered a multi-professional community upskilling programme that was fully inclusive of LA staff.

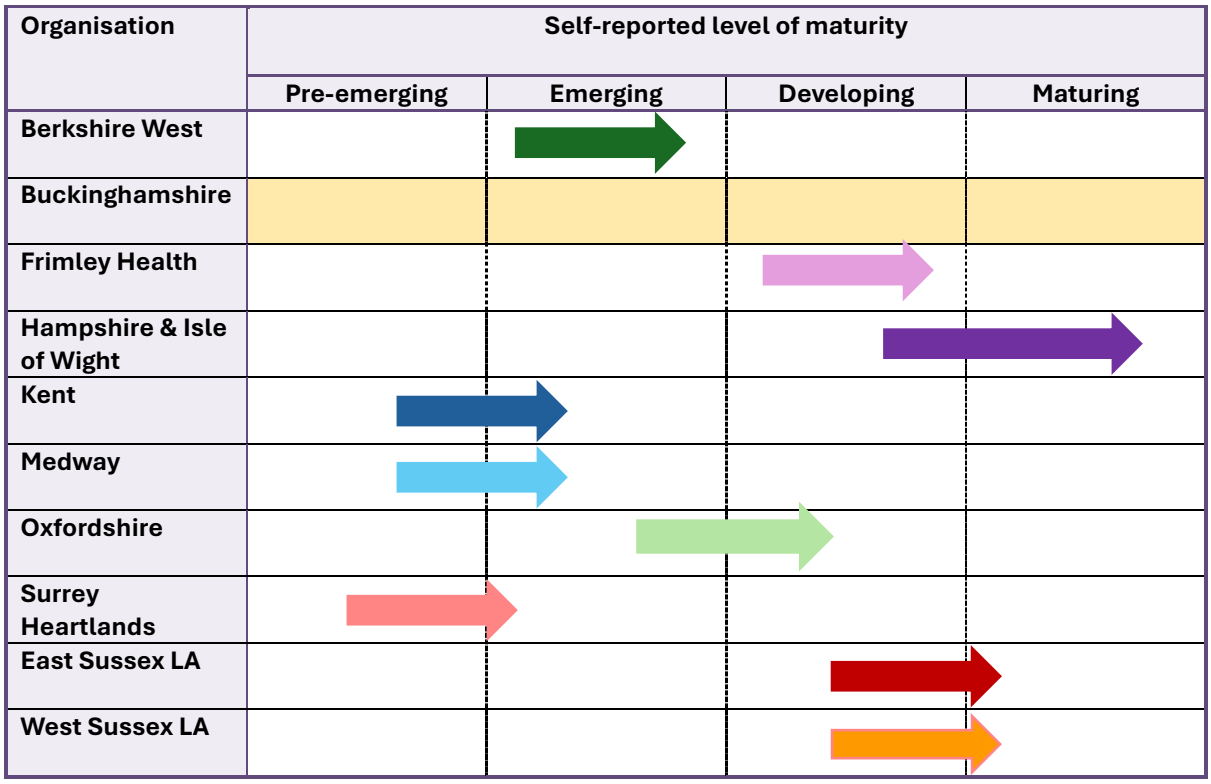
> *'We also developed 'Opportunity Mobility' through our OT Lead network to offer OTs the opportunity to experience different services when they get itchy feet or want to explore different career opportunities.'*
>
> H&IoW

Dimension 2: Leadership and AHP architecture for social care

Fourteen activities are listed under dimension 2 (appendix 3), ten relate specifically to Principal and Strategic Lead Occupational Therapists (PSLOT) (section 4.2.1). The remainder cover a wider range of leadership and OT influence in the services (section 4.2.2). Also reported in this section is a monograph about the Oxford Front Door Team (Box E).

An overview of self-reported level of maturity for dimension 2: Leadership and AHP Architecture is illustrated in table 5. The organisations listed either relate to place-based partnerships e.g. Berkshire West, a local authority e.g. East Sussex LA, or an ICS e.g. H&IoW. The detail about the level of maturity of the specific activities, under dimension 2, are set out in sub-sections:

Table 5: Dimension 2: Leadership and AHP Architecture self-reported level of maturity



NB: No data available for Buckinghamshire

4.2.1 Principal and Strategic Lead Occupational Therapists

The Principal Occupational Therapist, often referred to, in the South East of England as the POT, is a council strategic role, working in alignment with the Principal Social Worker (PSW). The POT acts as a bridge between practitioners and senior management. They work to ensure occupational therapy staff are competent to deliver the OT vision for the residents in their council.

According to Somerset Council the role of the POT [26] is to

- promote occupational therapy within the council
- ensure excellence in professional practice
- measure quality within service delivery
- lead practice improvement
- develop a culture of professional pride.

The RCOT published a report [5], about the roles and responsibilities of POTs working in adult social care services in England, which listed four key roles and responsibilities:

1. Professional practice
2. Facilitation of learning
3. Leadership
4. Evidence, research and development

The POT network in the South East currently has eighteen members, nine are designated POTs, the remaining have senior management roles: two of whom are community service managers. A relatively new appointment is the POT in Reading Unitary Council (West Berkshire). The manager in Reading put forward a compelling case for this post [27] to provide strategic leadership for the occupational therapy team.

Berkshire West, H&IoW, and Sussex (East and West) commented on the statement **'All Principal OTs identify as an AHP Lead within their local authority'**. Berkshire West advised that there is still a **lack of recognition and understanding about the POT role and involvement in LA senior strategic meetings**, e.g. in contrast to the PSW role. All three organisations noted that a POT identifies as an AHP lead. One respondent would have preferred to have been called an AHP.

'All principal/lead OTs are fully engaged in SE PSLOT network. PSLOT and Chief AHPs have shared leadership across integrated teams'. (H&IoW)

The extent to which the POTs/OT council leads are **involved in their local ICS AHP Council and AHP Faculty varies** across the region. In Sussex the Chief AHP has left and the Sussex AHP Council/Faculty meetings have been cancelled. The BOB and Frimley AHP Faculty meetings are predominantly health and HEI focussed, so less relevant for social care staff. It has been suggested that a BOB health and social care OT community would be more beneficial.

'Lead AHP only disseminates key messages about AHP workforce Faculty/apprenticeships/ preceptorships'. (Kent and Medway)

Kent and Medway hold separate monthly AHP Council and Faculty meetings. Frimley, Kent and Medway, Surrey and West Sussex agree the involvement with the AHP Councils and Faculties is still developing. Although there is concern that the momentum will not be sustained when NHSE merges with DHSC.

Kent and Medway ICS suggested that **equality, diversity and inclusion are not fully discussed**, but should be business as usual. '*Staff should not have to fight to get access to facilities'*. This group noted unease about how the public treat the staff. They pointed out that neurodiversity has recently been added to the AHP faculty agenda (**pre-emerging**). Frimley agrees this is beginning to **emerge** as a topic for discussion and pointed out that : 'local authority representatives have been asked to join the system wide AHP EDI champion network. So far there has been representation from two of the local authorities in the system'. H&IoW observe that despite the fact that the ICB AHP EDI Programme Lead is actively involved in the AHP Council, and Equality, Diversity and Inclusion projects are run by the AHP Faculty (inclusive of LA colleagues), this has had limited influence on the POT network diversity. The lead OT for Dartford reported a focus on EDI is **developing**.

The respondents view about **engagement with the Royal College of Occupational Therapists** (RCOT) was split between **emerging** and **developing**. Those who opined the engagement is emerging recognise that meetings are open to both social care and health. Bracknell Forest Council invited the RCOT to visit to learn more about their activity, however they asked for greater proactive engagement from the professional body. Others were more positive and suggested the engagement is developing or maturing. One local authority funds three membership fees but pointed out that the Health and Care Professions Council is very supportive. The RCOT holds a leadership forum to which all POTs and lead OTs are invited.

POTs across the South East are actively engaged in the **national POT network** which is reported to be highly effective. This network is still developing and one local authority OT Lead confirmed that they have clearly defined and direct links into: DHSC, ADASS (Association of Directors of Adult Social Services), LGA (Local Government Association) and SfC via this group, which led to them participating in the LGA review into the role of an OT. Three council representatives agreed that the engagement with the PSLOT network is **maturing**

Four respondents advised there is POT representation in all health and social care strategic decision-making and pathway development activity e.g. intermediate care and care workforce pathway: In Surrey Heartlands this is still **emerging**; In Berkshire West it is **developing** with mostly POT representation in all health and social care strategic decision-making and pathway development activity e.g. intermediate care and care workforce pathway; it is **maturing** in H&IoW (see Box D) and in West Sussex the POT represents adult social care on the Sussex major review of public health practice and quality committee, advising on demand, workforce and practice.

Strategic relationships are central to establishing effective links across the broader care and health systems. For some these relationships are patchy, very dependent on individuals and not part of the organisational structure and the role is confined to adult social care (East Sussex). In Surrey there are strong working relationships between the ICS Chief AHP and the local POT.

Box D: Hampshire and Isle of Wight POT involvement in social care and health decision making and pathway development activity

'There are Principal/ Lead OTs in all four Local Authorities (LAs) who are involved in all AHP strategic decision-making and pathway development through our AHP Council, AHP Faculty and OT Leads network, as well as sub-groups like our AHP Support Worker Strategy Implementation Group. The H&IoW AHP Faculty and Council are fully engaged in SE AHP Workforce Delivery Group, Regional Strategy & Resources Board, and Regional Council. The adoption of the AHP Support Worker Competency, Education and Career Development Framework within HCC is an example of POT influence to support change. They were able to articulate how adopting the Framework would support the Reablement Service, embed OT principles throughout all its assessment and interventions, which is a key aim of the service. The implementation of the AHP Support Worker Competency, Education and Career Development Framework by a POT provided evidence to demonstrate they could provide uniformity of skills across the staffing group and reduce duplication of work to ensure that service users receive the right service at the right time. Chief AHP and PSLOT – shared leadership across integrated teams.'

Surrey Heartlands is **developing** a strong working relationship between ICS Chief AHP and the POT. Similarly across West Berkshire and Frimley i.e. local authority OT leads enable collaboration about integrated projects e.g. postural management in care homes. In Oxfordshire strategic leadership has led to the development of the Front Door Team (**maturing**) as explained by the Head of Hospitals, Home First Neighbourhood Teams: *'Our Band 5 was amazing and she carried on doing some shifts for us when she was employed by social care, she was the best link that we had. She kept us fully informed. It was just out of coincidence that she had previously worked for our team, and she'd actually recruited some champions within our team. She has told us how to write our notes so that when social care pick them up they can review these notes really quickly and pull out the information they need'.* See monograph overleaf (Box E).

Box E: Setting up Oxfordshire County Council Front Door Team A discussion with Emma Pass, Practice Supervisor Occupational Therapist

When Emma qualified, as an OT, she wanted a job that enabled her to rotate through different services. Her first job was at Nuffield Orthopaedic Hospital, where for 18 months she gained experience on the wards. As part of the rotation Emma worked on orthopaedic wards, and a paediatric ward. Emma noted: ***'at the beginning of my career, I was concerned about patient discharge processes and the disconnect between the services'.***

Her next job was in a small county wide adult social care OT team that supported other teams who were struggling to manage caseloads. This team was disbanded, and she was employed as a Practice Supervisor in the Home First Team (HFT) this was a very demanding role in a new service. Emma explained: '*the ethos of this service is about getting people home when they are discharged, and medically well enough. Those with lived experience have their assessments at their bedside at home, so creating less of a delay in discharge for these people from the NHS'.*

Once Discharge to Assess was established across the wider system, the services changed, and all discharge patients were included. The HFT and hospital social work teams were brought together and then sub-divided into four geographically located neighbourhood teams (NTs). At this time Emma proposed that they establish a new Front Door Team (FDT), which was launched alongside the NTs.

The current FDT was established in 2022 and is the gatekeeper to the service and screens the patients through the TOCH (Transfer of Care Hub). Emma decided: *'what was needed was a dedicated team to work closely with the wards, hub bed teams patient flow leads, and community services such as Age UK. The TOCH team work with many different wards and it is important, to successful transfer of care, that the ward staff have a key point of contact'.* The FDT spends time on wards to train the staff about the service. The staff on the ward can contact the FDT directly if they have any concerns about patients going home.

Emma has been working in the HFT for four years. The team has grown from six staff in 2021 to nine in 2025. On a monthly basis they support and make pathway decisions for 400-550 patients. Between January 2025 – May 2025 they screened 592 community referrals.

Emma explained: *'the FDT is the key to successful integration. We have regular communication with therapists and discharge teams and continue to build links. There's a lot of staff involved in hospital discharge, so having links is vital. We also have expertise in what's possible in the community, that is fundamental when preventing barriers to hospital discharge'.*

Band 7 Therapy Team Lead, based in the Discharge Liaison Hub John Radcliffe Hospital stated: '*The front door team has been a great support in the discharge planning process for hub bed patients. They are approachable, responsive, and work collaboratively, which really helps streamline care. Their involvement often reduces the need for a social worker assessment, enabling more timely and efficient discharges. Overall, their input makes a positive difference and supports better patient flow.'*

4.2.2. Leadership and occupational therapy (OT) influence in the services

The opportunity to influence is often determined by those who are engaged in a specific activity and not solely those who have senior posts. According to recent nursing research[28] '*situational leadership is a follower-centred leadership skill that enables leaders to adapt their leadership style to achieve optimal management results, facilitate the achievement of organisational goals, and increase follower satisfaction and growth'*.

Three comments suggested there is some activity engaging a wider community in leadership activity: for Frimley and Surrey Heartlands this is still **emerging**. In particular, Surrey Heartlands noted there are: 'some advanced practitioner and special interest practitioners'. An example of **best practice** is where East Sussex POT noted that there are **teams chats with health about complex referrals – everyone knowing and enabling adults**.

Evidence-based practice is key to delivering complex care. In West Berkshire they reported this a still **emerging** and there is some use of critically informed evidence-based approaches to advocate and lead operational and transformational change in complex situations and systems, and the enablers for this have been clinical voices and commissioning managers. Across Sussex they are clear this is **mature.** They work with excellent data teams and explained that evidence is key to their work, e.g. evidence was used to inform the recent work on reablement.

In 2024 the British Geriatric Society (BGS) published a report entitled 'Reablement, rehabilitation, recovery is everyone's business'[29], in which it was stated that *'ensuring no older person is left behind requires integrated workforce planning for population health and strong collaborative leadership within integrated systems.* It also mentioned the importance of senior leadership in a rehabilitation service (Box F). The South East LAs' commitment to senior leadership for this service is set out in table 6. It is encouraging to note that both H&IoW and West Sussex reported the commitment as maturing.

Box F: 12th message in BGS report about reablement, rehabilitation and recovery is everyone's business.

'Senior leadership is critical for a strategic and sustainable approach to planning and delivering rehabilitation for older people. Systems should identify a senior officer or Non-Executive Board member with a specific role in assuring equitable access to rehabilitation, attuned to the needs of older people and continually improving the quality of service delivered.'

Table 6: Examples of how authorities commit to having senior leadership for rehabilitation services

Organisation	Pre-emerging	Emerging	Developing	Maturing
Kent and Medway ICS	Agree with this statement, unfortunately no buy-in from the Trust which invests in doctors and nurses but not therapists. In social care we provide reablement services. There is a lack of understanding about what OTs do from non-OTs. This is evidenced by the lack of resources to support the service. Nurses have safe staffing levels that do not exist for OTs.			
East Sussex LA		Not a priority for social care because it is primarily a health function. It should be included in Social Care Needs assessments. Community rehabilitation (OT and physiotherapy), i.e. review the person at the beginning of the journey and help those with lived experience to get this support. This is the **GAP in the service.** If it was resolved it would further aid discharge. Not a remit for those employed under the Care Act. There are very few staff employed by social care who provide a reablement services. In Sussex they have recently started an OT leadership community of practice for		

		all/any one working in OT to network, meet and discuss services provided.		
Frimley ICS			Head of AHP, AHP Workforce manager and Practice Development lead roles in ICB structure.	
Hampshire & Isle of Wight ICS				There are Principal/ Lead OTs in all four LAs who are involved in all AHP strategic decision-making and pathway development.
West Sussex LA				£1m has been invested in reablement. The Executive Director of Adult Social Services is an inspirational leader who asked the questions: 'W*hy not reablement?* *'Why are OTs not both inwardly and outwardly facing?'*

The ICS implementation guidance[30] lists five key principles of effective clinical and care professional leadership (CCPL):

- Principle 1: Integrating clinical and care professionals in decision making at every level of the ICS
- Principle 2: Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities
- Principle 3: Ensuring clinical and care professional leaders have appropriate resources to carry out their system role(s)
- Principle 4: Providing dedicated leadership development for all clinical and care professional leaders
- Principle 5: Identifying, recruiting and creating a pipeline of clinical and care professional leaders

Four respondents commented on the extent to which these principles are applied, to enable more diverse, and integrated leadership, varies across the region (see table 7).

Table 7: Examples of how authorities engage in the clinical and care professional leadership principles

Organisation	Emerging	Developing	Maturing
East Sussex	POTs utilise these principles, but it is virtually impossible to get the voice of social care heard. Really difficult as two different bodies. Lead AHP roles, in both sectors, are critical key enablers.		
Frimley		We have a Clinical and Care Professional lead (CCPL) at system level - AHP CCPL role.	
Hampshire & Isle of Wight		There was POT representation at recent ICS Clinical and Care Professional Leadership event.	
West Sussex			We have very positive senior leadership training and coaching approach to leadership. The managers/team managers self-assess their needs. There is significant investment designed to improve culture and effectiveness of leadership.

Dimension 3: Attracting and Recruiting the AHP Social Care Workforce

Figure 8: Dimension 3 sections and sub-sections

Eleven activities are listed under dimension 3 of the AHPs supporting integration framework: attracting and recruiting the AHP workforce (appendix 4). As shown in figure 8 the findings for this dimension are grouped under the following headings:

4.3.1. Occupational therapy student programmes and higher education
4.3.2. Staff new to working in local authority
4.3.3. Career development opportunities across health and social care
4.3.4. Support workforce

An overview of self-reported level of maturity for dimension 3: **Attracting and recruiting the social care workforce** is illustrated in table 8. The organisations listed either relate to place based-partnerships e.g. Berkshire West; a local authority e.g. East Sussex LA, or an ICS e.g. H&IoW.

Table 8: Dimension 3: Attracting and recruiting the social care workforce self-reported level of maturity

Organisation	Self-reported level of maturity			
	Pre-emerging	Emerging	Developing	Maturing
Berkshire West				
Buckinghamshire				
Frimley Health				
Hampshire & Isle of Wight				
Kent				
Medway				
Oxfordshire				
Surrey Heartlands				
East Sussex LA				
West Sussex LA				

On the following page is a monograph about parity of opportunity for occupational therapists working in Social Care- A Principal Occupational Therapist's view (Box G).

Box G: Parity of opportunity for Occupational Therapists working in Social Care- A Principal Occupational Therapist's view. A discussion with Carole Lee, Reading Borough Council (Unitary Authority)

Carole Lee is very positive about the support she has from her managers in this Unitary Authority. Carole is a passionate advocate for occupational therapists (OTs) who work in social care.

POTs have a wide portfolio of responsibilities including managing OT quality assurance, strategic influence on prevention and wellbeing, and how social care and health work together. She has oversite of the equipment service, and directly managers the Technology Enabled Care Team (TEC), the Moving and Handling OT lead, and the new Falls Prevention Team. As well as leading on the Optimising Care Project.

Carole is extremely proud of the achievements across the Occupational Therapy teams, including OTs, OT Social Care Coordinators, and OT apprentices. "In Reading, we have successfully supported seven individuals to qualify as Occupational Therapists. This year, both of our apprentices achieved First Class Honours degrees — a remarkable accomplishment that reflects their dedication and the strength of our support".

In 2024 Reading Borough Council published its Workforce Strategy 2024-2029 which has six Strategic Priorities including developing, rewarding and recognising the workforce, and integration. The Council recognises the importance of focusing on prevention, upskilling staff and removing barriers to the use of technology. It also understands the value of increasing joint learning experiences. But funding is limited and is required to meet all the general adult social care training needs.

Carole is working with her POT colleagues in Wokingham Borough Council and West Berkshire Council to co-develop a portfolio-based OT preceptorship (competency induction) programme. She recognises that there is no national programme for OTs starting in Social Care.

As she explained: "Because of the diversity of OT roles in health and social care, when students graduate they don't have all the technical skills needed, and we don't expect them to hit the ground running. But even those who have been working in other areas such as hospitals don't have the technical skills required to work in the community with residents who have complex needs". In stark contrast every newly qualified Social Worker is enrolled on a standardised University Assessed and Supported Year in Employment (ASYE) course. This programme is funded by their employing Council. However, some of this funding is provided by SfC. This approach is supported and promoted by ADASS (Association of Directors of Adult Social Services). Unfortunately, there is no similar SfC funding to support OTs, and the Royal College of Occupational Therapists Workforce Strategy 2024-2035 does not specifically focus on the needs of OTs new to Social Care. This presents a significant challenge for local authorities aiming to develop a consistent national approach to recruiting and developing a skilled OT workforce.

4.3.1. Occupational therapy student programmes and higher education institutions

4.3.1.1. Increasing OT placements

It is well recognised across the South East of England that there is a national shortage of registered OTs. Occupational therapy is included on the governments' July 2025 list of higher skilled eligible occupations (code 2222)[31]. However, there is very mixed views about increasing student placements.

Buckinghamshire and Frimley reported a poor uptake of local authority placements. H&IoW is actively offering social care as an AHP career option and working to liberate placement expansion in the local authorities. According to West Sussex expansion is restricted by LA business needs.

'Only one POT confirmed they have increased student placements.'

H&IoW

Repeatedly staff mentioned the difficulty of students needing to **rely on cars** to gain placement experience in social care. This situation has been exacerbated by the delay in booking driving licence tests. The Expert Reference Group (ERG) recognised this problem but pointed out that fewer people are learning to drive because of the rising costs of owning a car.

Kent County Council and Berkshire West reported a more positive situation as illustrated in Box H.

Box H: Examples of occupational therapy student placement development in social care

Kent County Council: "OT *student placements for 2025/26 are expanding, with more adult social care settings and partner universities participating – facilitated by better IT access. There is also potential to grow further by involving non-traditional OT roles and exploring alternative placement models."*

Berkshire West: reported *"Many OT students gain practice placement experience through the LAs and this provides a well-rounded experience and exposure to social care and health settings. Students are from a variety of HEIs, in and beyond the SE region (for example: Coventry University, University of Hertfordshire, University of Nottingham). Placement evaluation and student feedback is sought by placement providers in addition to the HEI placement evaluations. There are initial ideas for a shared/common placement evaluation to be developed. "*

In contrast Oxfordshire County Council explained why there is no planned increase in student numbers:

- There is a notable impact of OT apprenticeship placements on the direct entry route resulting in fewer direct entry student placements available.
- There is no role for effective coordination for AHPs unlike social work which has a placement coordinator based in Oxfordshire Social Care Academy.

It is acknowledged that the system could potentially do more to expand placements although '*the workforce is exhausted'*. Some LAs reported receiving £7,500 in student tariff which the team benefitted from, for other LAs who did not receive the tariff they are discouraged from taking additional students.

Across Kent the model of occupational therapy student placement at Dartford and Gravesham NHS Foundation Trust is commended: they have a large number of student placements from various universities and operate a 2:1 student supervision model. Furthermore they have an annual international placement from Australia and plan to host a joint placement with Kent and Medway NHS and Social Care Partnership.

4.3.1.2. Apprenticeship programmes

The national AHP apprenticeship data signifies a significant increase in the number of occupational therapy apprenticeships. 1,758 OTs have trained via this route since 2018/19 when the programme first launched; 354 in the South East region of England (NHSE, 2025) (see appendix 5). The NHS long term workforce plan[32] commits to apprenticeship expansion and plan by 2031 and that 22% of training for all clinical staff to be via apprenticeships, compared to 7% in 2022/23.

Increasingly, organisations are opting for the apprenticeship model, rather than direct entry, to develop the next generation of OTs in social care. Often the decision to have apprentices is made by the service lead rather than strategically directed (Kent County Council).

However, there is concern about the sustainability of this model in LAs. Partly because of the small pool of potential apprentices and partly because of the demands on the workforce. The POT in East Sussex explained: *'we have five apprentices in year one and five in year two. We have to assign a Band 6 from existing workforce to an apprentice support post. Staff already support many staff as we have a lot of growth in the OT workforce in East Sussex. Furthermore, we do not have the support workforce to create a supply pipeline. Currently the evidence required by Skills England (formerly IFATE the Institute for Apprenticeships and Technical Education) is onerous and some students have left because they couldn't manage the workload'*.

Some LA experience is very positive (see Box G): the route works well with the unregistered workforce, and they have good skills when they qualify as OTs. They recognise that if the LA invests in apprenticeships the successful apprentices then choose to stay. H&IoW AHP Council led a collaborative commission of an OT apprenticeship programme. The first graduates joined health and care organisations in July 2024. Practice placements across health and social care were agreed and introduced as part of this collaborative. It is important that the apprenticeships are mapped against Band 5 posts to ensure they have employment when they have successfully completed their degree course.

Although, as Oxfordshire County Council acknowledged, the impact of apprentices is beneficial for "Grow Your Own", there are challenges with delivery: this is because of caseload; their study time requirements, which affects clinical capacity, and there is no funded backfill. Unlike social work apprentices who go into a social work apprenticeship role.

An in-depth examination of the apprenticeship developments in Berkshire West and Frimley, as part of this project, concluded that **apprenticeships support workforce retention; strengthen the career progression pathway; and with a focus on internal investment the likelihood of long-term retention increases**.

This assertion was based on data for the academic years 2022/23 - 2025/26 which was self-reported by partners in Health (Berkshire Healthcare NHS Foundation Trust, and Royal Berkshire Hospital NHS Foundation Trust) and Social Care LAs (Reading, West Berks, Wokingham, Royal Borough of Windsor and Maidenhead, and Bracknell Councils). There has been significant overall growth (57% increase) in the total number of apprentices from 2022/23 to 2024/25 according to available data in Berkshire West (figure 9). This includes eight more apprentices. However, there were no more social care placements offered in 2023/24 for the additional three social care apprentices.

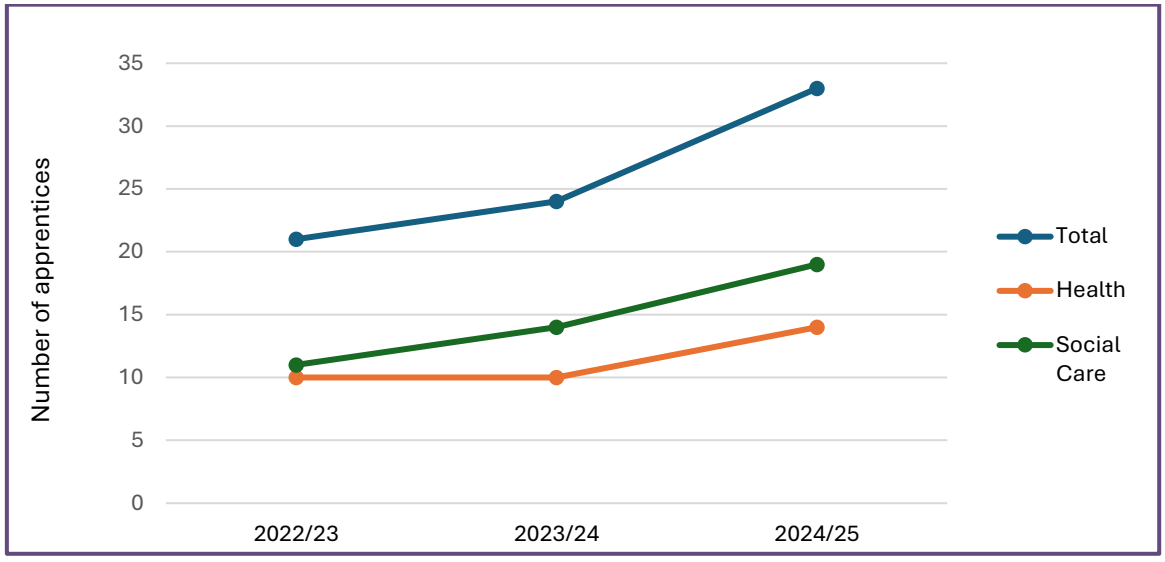


Figure 9: Berkshire West Occupational Therapy Apprentices

As well as an increase in the number of placements offered for occupational therapy apprentices there is also some evidence that the variety of type of placement (in both social care and health -see (appendix 6) is rising. With this variety of workforce placements, there is the potential for greater reciprocal placement arrangements, between health and social care.

POTs and AHP leaders in health and social care reported that OTs on the apprenticeship pathway are more employable than their counterparts on the direct entry programmes, because they demonstrate higher clinical skills and greater confidence. Despite best intentions, not all direct entry OT students have a placement in adult social care.

4.3.1.3. Promoting the value of a social care career to students

Many of those who participated in ALIGNS observed that students who had experienced a placement in Social Care chose this option for their first employment post qualification. Further education institutions and higher education institutions (HEIs) have a major role in influencing first post destinations. This fact is recognised by many of the health and care service provider organisations in the South East of England (table 9). Although there is varying levels of capacity in LA to work with HEIs to recognise and promote the value of a social care career.

Table 9: Examples of LA supported activities that promote a career in occupational therapy in social care

Level of maturity	Organisation	Activity
Pre-emerging	Wokingham Borough Council	Promotional talks (by OTs and POT) to FEIs Offer work experience to students.
Emerging	Berkshire West Councils (West Berkshire, Reading, Wokingham Borough)	Ad hoc occurrences of work experience for A - Level students (West Berks, Reading and Wokingham Borough Councils). West Berks Council also provides career talks to local secondary schools and FEIs. This is supported by their talent acquisition team and newly qualified OTs attend career fairs.
Developing	Medway Unitary Authority	Attend FEI events to promote OT career opportunities.
Maturing	Kent County Council	Adult social care fully recognises the value of a social care career and seeks to promote this with HEIs at every opportunity.
	H&IoW	♦ Held an AHP career event aimed at school children ♦ An event aimed at T-Level and A-Level students at our FEIs. This was followed up with offers of placements, tester days and work experience. All inclusive of LA AHPs. Actively offer social care as an AHP career option. ♦ Take part as a system in Employability week at HEIs, followed-up with offer of career conversations and shadowing.
	West Sussex	♦ Yearly webinars with Brighton University OT students titled – *The day in a life of an OT in Social Care* ♦ Employers meeting – discuss course content ♦ Support students with completing application forms.

In addition two senior OTs employed in Kent and Medway heath services provided examples of how they work with Canterbury Christchurch University (CCCU) to promote OT as a career:

- The lead OT at Dartford and Gravesham NHS FT explained they attend CCCU employers' day to talk about the OT role at their Trust.
- Senior OTs employed in Medway Community Healthcare outlined the good relationship they have with CCCU. They described how they recruited four newly qualified OT practitioners following their presentation to 3rd year OT students. They also pointed out that during the presentation they illustrated the different skills sets needed to work in health or social care.

4.3.2. Occupational Therapists new to working in local authority

4.3.2.1. Newly qualified OT rotation incorporating Social Care

The POTs and senior OTs in health advised that facilitating clinical rotations between health and social care is not currently provided for newly qualified OTs across the region. The mutual benefit for the staff and services is appreciated; however it is challenging because of operational difficulties, no funding to support such an initiative, and HR considerations. Although BOB AHP Council and Faculty support rotational posts, the workload to arrange is not sustainable. OT apprentices are given this opportunity as part of their pre-registration clinical placements. The monograph in Box E highlights the benefit of working in both sectors at an early career stage.

4.3.2.2 Preceptorship for OTs working in local authorities

The majority of OTs employed in NHSE have access to a formal preceptorship programme based on the AHP preceptorship standards and framework[33]. This is not the same for OTs working in social care and it is recognised that more could be done to improve the preceptorship offer for this workforce. Preceptorship is pastoral support for those who are newly qualified, internationally trained, return to practice or new to role.

In 2023 the Health and Care Professions Council (HCPC) published the Principles for Preceptorship[34]. The following year NHSE published the AHP preceptorship standards and framework.

The HCPC preceptorship principles include four statements relevant to integration (Box I). In the AHP standards and framework it states preceptorship is: 'A period of structured support and development during periods of transition, during which the AHP will be supported to help them grow in confidence as an autonomous and accountable practitioner'.

Box I: Selection of HCPC preceptorship statements

- Preceptorship is a structured programme of professional support and development designed to improve registrant confidence as they transition into any new role (Principle 1).
- Preceptorship is an important investment in a registrants' professional career (Principle 2).
- All registrants should have access to a quality Preceptorship programme. It demonstrates the value of individual registrants' health, wellbeing and confidence during times of transition (Principle 2).
- **Preceptorship should not retest clinical competence but instead, empower the Preceptee to reflect on what they bring to their role and identify support needed to develop their professional confidence** (Principle 3)**.**

Five OTs[d] referred to the established and fully funded social work ASYE (Assessed and Supported Year in Employment) programme [35] (see discussion with Carole Lee, Box G).

[d] Buckinghamshire County Council, East Sussex County Council, Medway Unitary Authority, Oxfordshire County Council, Reading County Council

The councils that provide a bespoke programme for the newly qualified OTs (e.g. Kent County Council, West Sussex County Council (Box J)) explained that their programme continues to be developed. Some of the Councils continue to focus the preceptorship programme on competency to practice, rather than pastoral care support which is the tenet of preceptorship (see box I). In part this is because the direct entry OT students do not spend sufficient time in social care placements to develop the different competencies required to work in this sector.

Box J: West Sussex County Council Early Practice Framework

In 2018, West Sussex County Council developed an Early Practice Framework. Version 9 was produced just one month before the NHSE AHP preceptorship standards and framework was published. The focus of the Council Early Practice Framework is on the standards of proficiency to ensure safe and effective practice. The Council Professional Practice Development lead pointed out that the HCPC standards of preceptorship have to be translated into Social Care, and the council is about to review their framework to align more closely with the AHP preceptorship standards and framework.

H&IoW AHP Council and Faculty has produced a preceptorship charter (Table 10) which states a commitment to promote the importance and relevance of effective and inclusive preceptorship to all newly registered AHPs across their system.

Table 10: Hampshire and Isle of Wight AHP preceptorship charter

Infrastructure Work in partnership with Higher Education Institutions (HEI) to introduce preceptorship purpose and objectives during the last year of training. Incorporate expectations and benefits of preceptorship throughout the recruitment process from advert to induction.	**Information** Create a standard information pack for newly registered AHPs clarifying expectation, purpose, and objectives of preceptorship. Work with individual organisations to identify specific organisational material, and identify an effective way this will be shared across the system and with newly registered AHPs.
Programme Work with organisations to ensure that all preceptees commence a programme within two months of their start date. Work with Lead AHPs and Preceptor Leads to review context of programmes to ensure multi-disciplinary approach, ideally to be in-person, provide a wide variety of content to ensure relevant and meaningful learnings and reflection. Provide a 6–12 month follow-up to encourage reflection and consolidation of learning.	**Support** Produce guidelines on the role of the line manager/supervisor in supporting preceptorship learning and ensure protected time is prioritised. • Develop the AHP Faculty web pages to host AHP preceptorship information, including the outcome from the national AHP preceptorship programme. • Engage with the national programme of training preceptor supervisor with a train the trainer programme and support the transition from preceptee to preceptor. • Consider an annual system wide celebratory event for preceptees.

In Berkshire West the POTs and lead OTs, working in the Local Authorities, collaborate to share best practice between them. Wokingham Borough Council is part of BOB AHP Preceptorship Workforce Development Group and in collaboration with Reading, Wokingham, and West Berkshire the POT is drafting an OT preceptorship programme aligned to a) the four pillars of

practice, b) the RCOT support for those transitioning from pre-registration to practice, and c) the ASYE programme. The Royal Borough of Windsor and Maidenhead staff access the NHS AHP preceptorship programme via Frimley ICS and self-assess against the NHSE AHP preceptorship organisational self-assessment tool.

There is very limited preceptor specific training for OTs working in social care. OT supervisors often take on this additional role. Kent County Council's preceptors currently take part in an introductory orientation programme and there is scheduled additional training for this group.

Only two POTs in Hampshire reported that they employ legacy mentors[e] to support those new to social care. East Sussex POT thought this was a very good idea and Better Care Funding could be sought to support this initiative.

The respondents referred to the support that is provided for those returning to practice. BOB ICS has produced an AHP Return to Practice resource which includes local authority placement offers. Since 2019 Buckinghamshire has supported six OTs returning to practice. However, Oxfordshire does not have any Return to Practice OTs. H&IoW has delivered a return to practice programme across social care and health. In contrast for social workers returning to work, there are formal policies and procedures in place with a handbook to support them.

4.3.3. Career development opportunities for social care OT workforce

4.3.3.1. Guest lecturing

Inviting OTs from social care to lecture on the pre-registration programmes encourages the learners to consider social care as an employment option.

H&IoW POT regularly gives lectures at HEIs, on proportionate care, long term conditions management and role of OT in social care. However, it is disappointing to note that HEI OT programme leads in the SE of England seldom invite OTs in social care to speak to their students, although the service-based staff expressed a willingness to do so. Some HEIs no longer have guest lecturing opportunities.

Examples of OT staff giving OT social care lectures include:

- An OT employed by Oxfordshire County Council, with Approved Mental Health Training (AMHT), regularly lectures on the Oxford Brookes pre-registration OT course.
- Kent County Council (KCC) POT and Senior OT managers guest lecture for CCCU.
- The Buckinghamshire AHP workforce programme Fellow, an OT by profession, and experience of working in social care, was invited by Buckinghamshire New University to speak to the OT students

4.3.3.2. Post-registration opportunities between social care and health

Senior OTs based in Berkshire West explained that local authorities and the NHS do not recognise each other as similar employers. Consequently, there are significant human resource barriers to facilitating staff exchange, or staff movement between the two sectors, e.g. terms and conditions, pensions, annual leave. Nonetheless, some organisations provide opportunities for staff to learn together and learn about the 'other' sector:

[e] In this context legacy mentors are experienced OTs, usually in late career, who provide coaching, mentoring and pastoral support to OTs who are at the start of their career or who are newly appointed into social care.

- Oxfordshire County Council has supported a Band 5 physiotherapy rotation into Adult Social Care Home First team.
- In H&IoW there are fully aligned AHP workforce development frameworks for social care and health e.g. integrated AHP support workforce strategy, rotational posts across health and social care. There is fluidity across health and social care as equal partners. Local authority AHPs are included in any AHP Faculty training e.g. patient and public health training and multi- professional community upskilling programme.
- Kent and Medway ICS ran a very successful Occupational Therapy Development programme: The SPRINT programme (see Box K).

Box K: The Kent and Medway ICS Sprint programme

SPRINT programme partners:

Kent County Council kent.gov.uk; NHS Kent and Medway; NHS Kent Community Health NHS Foundation Trust; NHS Maidstone and Tunbridge Wells NHS Trust; NHS Kent and Medway NHS and Social Care Partnership Trust; NHS Maidstone and Tunbridge Wells NHS Trust; Kent and Medway AHP Faculty

This programme represents specific investment in the skills, career and personal development of Band 6/ KR10 staff.

Programme objectives:

- To support recruitment and retention
- To encourage OTs to work across services to increase workforce flow and confidence
- To improved patient outcomes
- To develop the skills needed to work in modern health and social care settings
- To raise awareness for the roles and career pathways within OT
- To deliver a creative and innovative leadership programme
- To provide an opportunity for NHS and social care organisations to form links and build relationships
- To provide an opportunity to influence the way in which OT works across the system

A key activity was the 'Sprint' – A two-week shadowing experience in Acute, or Community, or Mental Health or Social Care. A chance to experience a completely different area of OT and gain an insight into the mechanics of another part of the wider system and how the baton is passed. As a result of the programme the OT course participants reported over 50% increase in *strong relationships with a network of Occupational Therapists across different services and organisations*.

*'The Sprint Programme was a **great opportunity to share experiences** across services.'*

4.3.3.3. Internationally educated and trained Occupational Therapists

There is very little evidence across the South East of England that local authorities proactively recruit internationally educated and trained OTs; other than H&IoW where the local authorities took part in the international recruitment collaborative, supporting the development and delivery of the internationally recruited transition programme.

Some POTs reported that they employ internationally educated AHPs (East Sussex, Surrey Heartlands), others that they did previously but it was not sustainable as these staff moved on very quickly. Oxfordshire County Council observed that the Council does not advertise for internationally educated and trained OTs, although it does for internationally educated and trained social workers. The OT lead for Dartford and Gravesham NHS Trust advised that although the Trust had successfully proactively recruited eight internationally trained OTs, they have paused this activity because of financial constraints.

4.3.3.4. Additional examples of effectively attracting and recruiting the AHP social care workforce

Seven examples of how organisations effectively attract and recruit OT staff were provided (table 11).

Table 11: Examples of attracting and recruiting staff

Organisation	Examples of approach to attracting and recruiting staff
East Sussex	The Council has won a number of awards, and these are publicised as part of any recruitment campaign and are celebrated by existing staff: ♦ Housing Foundation Award ♦ Innovation awards The team also promotes the fact they listen to the service users and maintain a low waiting list.
H&IoW	♦ Developed 'Opportunity Mobility' through the OT Lead network. This offers OTs the opportunity to experience different services when they get 'itchy feet' or want to explore different career opportunities. Sharing and taking on board best practice and showcasing examples of OT in local authorities within systems, regions and nationally.
Medway Unitary Authority	♦ Community based hybrid working ♦ A supportive team offering regular supervision The approach is successful as evidenced by the fact that four OTs left the authority and then returned.
Oxfordshire County Council	Proactively promotes OT careers in adult social care: ♦ Podcasts ♦ Presenting at Community Care live conference 2025 (2nd year running) ♦ OT career promotion in schools, - each locality team is challenged to go to one school in their area ♦ Stall at Oxford Pride ♦ Stall at careers fairs e.g. Kassam stadium. ♦ Adult social care workforce career development stories.

Two health care providers also noted activities that support recruitment and retention of OTs:

- Dartford and Gravesham NHS FT:
  - Rotations across trusts/charities provides additional clinical experiences
  - Development of clinical learning framework to ensure 'clinical specialist' knowledge can be developed. This is mapped against RCOT pillars of practice[36]. Everyone works towards the same framework, with the concept that a Band 7 may be an expert in orthopaedics but a novice in stroke.
- Medway Community Healthcare:
  - publishing in OT NEWS and speaking at a local conference saw an increase in applications
  - forward thinking team – good to be research active because newly qualified OTs are interested in career development.

4.3.4. AHP support workforce in social care

In 2021 HEE published the AHP support worker competency education career development framework[25]. Three local authorities (Royal Borough of Windsor and Maidenhead (RBWM), West Berkshire and Wokingham) self-reported information about the AHP support workforce (table 12). The Head of Community Services at RBWM reported positive feedback from service users, about the 'one conversation' consistent approach.

The OT leads in the Berkshire West case study site were asked to consider what factors would enable the OT support workforce to assist integration and what the barriers might be. Their reflections are set out below:

Favourable circumstances that would enable the AHP support workforce to assist integration:

- POT leadership, relationships and collaboration across local authorities and OT leads in local NHS provider organisations. An example is the Frimley OT collaborative. The POTs in Reading, Wokingham, and West Berkshire Councils have liaised about developing OTA progression pathways.
- Support and collaboration specific for support workforce development across the system.

Challenges/barriers to the AHP support workforce enabling integration:

- Wide variation in AHP support workforce education and training and career development opportunities and future workforce pipelines.
- Capacity and demands of existing workloads impede development of existing OTA workforce.
- Discrepancy in pay between health and social care (at all levels).
- Variation in deployment of support workforce role.
- Differences in language between health/social care e.g. role titles: - Occupational Therapy assistant, Occupational Therapy Support worker, Social Care Practitioner present confusion and complexity.

Table 12: OT support workforce deployment and development in Berkshire West

Authority	Number of support workers	Comments about how OT support workforce is deployed and developed
Royal Borough of Windsor and Maidenhead (RBWM) Council	RBWM – 5 x OT Assistants (OTAs) Optalis contracted in for provider services such as intermediate care – 2 x OTAs	♦ All have graded, signed off competencies (like enhanced practice) within their roles. ♦ Promotes support workforce to engage with conferences/CPD etc, even if not pursuing apprenticeship e.g. AHP support worker conferences (Frimley ICS). ♦ Approach to OTA development and improving outcomes: Simpler cases were going to Trusted Assessors at NRS Healthcare, and new OTAs were getting complex cases. This has changed. The Council introduced "blitz days": 4 visits booked in allowing the integration of OTAs with OTs during visits, allowing OTAs to learn and develop competencies and skills through hands-on experience and collaboration.
West Berkshire Council	3 x OTA 1 x falls co-ordinator and 1 x SCP (Social Care Practitioner)/OTA	♦ OTA roles are less likely (than SCP which are easy to recruit to) to arise and will only do so when the previous person qualifies and moves to a qualified position. ♦ Recruitment is via advertisement/in-reach links with local colleges. ♦ Career talks to local secondary schools and FE, supported by their talent acquisition team and newly qualified OTs attending career fairs, and supporting work experience day (Feb 2025), in some areas this is indicated to be impactful for recruitment of SCPs. ♦ Many of the OT apprenticeship students are from local authorities as the reciprocal model works really well with unregistered workforce in LAs. All OT apprentices recruited internally from the support workforce. Those who have graduated have been retained.
Wokingham Borough Council	3 currently on the OT apprenticeship 1 joining in the summer 1 retiring soon 3 employed as OTAs don't wish to pursue OT apprenticeship.	♦ All start at "grade 5", and after 1 year in post, demonstrate SCP skills and evidence, portfolio goes to panel and progress to a "grade 6". ♦ Apprenticeships for unqualified staff have started since. ♦ No progression options other than OT apprenticeship pathway. ♦ Good retention in this workforce. ♦ Enhanced practice: engage in low-level moving and handling due to their experience, with support from qualified OT.

NB: For information about the Home First Support Worker initiative please see section 4.4.5.1.

Dimension 4: Collaborative learning, development, state of workforce readiness and AHP workforce initiatives

Figure 10: Dimension 4 sections and sub-sections

Nineteen activities are listed under dimension 4 of the AHPs supporting integration framework: collaborative learning, development, state of workforce readiness and AHP workforce initiatives (appendix 7). The detailed findings for dimension 4 are presented under the following eight sections:

4.4.6. Enhanced, advanced and consultant AHP initiatives
4.4.7. Digital working across social care and health
4.4.8. Potential new roles to strengthen integration

Also included in this section:

1. Kent and Medway's approach to proportionate care and trusted assessment (4.4.5.2.).
2. Two potential new roles to strengthen integration;
    - Enhanced practice and enhanced care as enablers to AHP integration across social care and health proof of concept (4.4.8.1.).
    - Extent to which volunteers can support people who are transferred from the acute setting into community settings with support from social care teams (4.4.8.2.).

An overview of self-reported level of maturity for dimension 4: **Collaborative learning, development, state of workforce readiness & AHP workforce initiatives** is illustrated in table 13. The organisations listed either relate to place based partnerships e.g. Berkshire West; a local authority e.g. East Sussex LA, or an ICS e.g. H&IoW.

Table 13: Dimension 4: Collaborative learning, development, state of workforce readiness & AHP workforce initiatives self-reported level of maturity

Organisation	Self-reported level of maturity			
	Pre-emerging	Emerging	Developing	Maturing
Berkshire West				
Buckinghamshire				
Frimley Health				
Hampshire & Isle of Wight				
Kent				
Medway				
Oxfordshire				
Surrey Heartlands				
East Sussex LA				
West Sussex LA				

4.4.1. AHP roles and their learning and development needs

The respondents provided comprehensive comments (4.4.1.1. & 4.4.1.2.) about the appreciation of AHP roles across social care and health and the level of understanding about the learning and development needs of this workforce.

4.4.1.1. Appreciation of AHP roles across social care and health

The local authorities commented extensively on this aspect of dimension 4. Their experiences and observations are collated in table 14.

Table 14: Levels of appreciation of AHP roles

Local Authority/Unitary Authority	Level of maturity	Experiences and observations
Berkshire West	Emerging	There is some mutual appreciation of AHP roles across the system, e.g. Berkshire OT conference (for all local authority and health OT colleagues) showcases together good practice and innovation of working together. **Challenges:** ♦ There are six local authorities all with a different structure depending on the locality, it can be difficult to know who provides which service. ♦ Capacity and demand on resources **Enablers:** OT professional relationships, connectivity and network.
Buckinghamshire	Emerging	More work to be done about how the teams communicate and work closer together.
	Developing	The health activities in the Transfer of Care Hub (ToCH) are more mature than in social care. The work of the ToCH helps with the wider understanding of AHP roles. This is evident from the fact that the Home First team, RICC (Rapid Response and Intermediate Care) team and the Health Integration team (HIT) all come together in the ToCH.
	Maturing	♦ Good appreciation of OT roles in social care.
Frimley Health	Developing	♦ There are programmes of work where teams link together e.g. discharge and flow and integrated teams. ♦ A professional collaboration meeting is held every eight weeks, when all health and social care providers attend.
H&IoW	Emerging	Developed an OT video 'Not what we do, why we do it' to promote and showcase the diversity of OT roles across the system. The library is still being developed and will include LA roles. Myth-busting occupational therapy - YouTube
	Developing	♦ Regular input, at AHP Council, from LA colleagues to understand implications and application of roles within LA. ♦ Some OTs represent adult social care on joint working groups, partnership groups. AHPs can support/complete: Care Act Assessments, Best Interest Assessments, Deprivation of Liberty Safeguards. Some AHPs are approved Mental Health Practitioners.
Medway	Developing	Joint meeting with all OTs across Medway social care and health is an opportunity to get together and appreciate each others' roles. Continuation of single handed training is the biggest challenge.

Oxfordshire	Pre-emerging	The way health and social care work is so different, *'it is important to champion adult social care and health rotations'*. This should include senior staff. An example of the benefit to the service, and service users, of staff who have worked in both sectors is illustrated in the interview with Emma Pass from the Front Door Team (Box E section 3.2.1.).
	Emerging	**We often find that when people talk about social care, they talk about social work**. The original timetable for the recent CQC inspection didn't mention occupational therapy.
	Developing	There is a mutual appreciation of all AHP roles across social care (local authorities) and health (NHS). In OT the staff always have to work that much harder to be appreciated. There is a constant push for what the OTs do to be appreciated and the importance of actually making clear in the notes the contribution OTs make and when they are signed by an OT. In the current climate (financial pressures), we have to show that everything we do is so essential and not just desirable. Oxfordshire is considering recruiting rehabilitation assistants, employed by health, to work in the rehabilitation (social care) pathway. Work ongoing to integrate more in the Community/Intermediate Care. There is some work to do in terms of the crossover points, integration and seamless delivery, particularly between community and intermediate care. There is still duplication between community therapy services and social care. *'We have staff who work into the transfer of care hub, that is completely integrated.'* **The way students are trained is key to integration. Unless students have had placements in the 'other' services when they qualify, they are not aware of how those services work.** It is important to extend skills and knowledge to improve service efficiency and outcomes; and to understand more about the extent to which tasks/ roles that other professionals perform could be undertaken by different AHPs in social care.

4.4.1.2. Level of understanding of AHP workforce learning and development requirements within both social care and health

The two main challenges to understanding workforce learning and developing needs are: a) the lack of funding in social care and b) if a member of staff leaves without recording this detail. The self-reported level of understanding of AHP workforce and development needs are listed in table 15.

Table 15: Self-reported level of understanding of AHP workforce and development needs

Local Authority/Unitary Authority	Level of maturity	Experiences and observations
Berkshire West	Emerging	♦ There is limited understanding of workforce learning and development requirements across both social care and health. It is dependent on individual workforce members. In social care it is evidenced through auditing of quality of practice – examples of Mental Capacity Act and record keeping. ♦ BOB AHP Faculty scopes development needs. ♦ West Berkshire POT preceptorship presentation at Berkshire OT conference (Nov 2024).
Buckinghamshire	Developing	♦ Good understanding of AHP workforce and development needs. ♦ Council knows what is required across adult social care. Care Home managers advise on training needs. However, no consistent approach to safeguarding and inappropriate referrals. There is no training passport, although there is some joint training for support workers.
Frimley Health	Developing	Integrated training bulletin is circulated, and all can attend Frimley ICS AHP and Academy training.
H&IoW	Maturing	♦ AHP Faculty OT roadmap and workforce strategy, included an analysis of workforce learning and development requirements within both social care and health. A multi-professional community upskilling programme fully inclusive of LA staff was delivered. ♦ H&IoW 'Opportunity Mobility' developed by OT Lead network offered OTs the opportunity to experience different services when they get itchy feet or want to explore different career opportunities. ♦ Through commissioning reviews and system transformation programmes H&IoW aims to maximise the AHP contribution in line with identified needs. This informs future workforce projections and AHP education, training, and development. The POT plays a lead role in sharing proportionate care skills with the wider MDT. ♦ OTs in social care train and support others for trusted assessment, manual handling and strength-based working; and support the generic skills of support workers, promoting the ethos of occupational therapy principles in their work. ♦ Learning opportunities shared with local authority colleagues through AHP Council and Faculty: • community upskilling programme, • allyship training • patient and public involvement training. ♦ Proportionate Care training, support workers conference, community of practice, and a mid-careers conference are examples of opportunities that has been shared at a system level.

Kent	Developing	East and West Kent ♦ Single handed moving and handling discharge into community. ♦ OT Sprint programme for Band 6 across health and social care – an intensive 4-week programme where participants shadow each other (section 4.3.3.2). ♦ Home First service Band 3 learning programme OT and PT competency (funded by health and social care). ♦ West Kent Integrated Neighbourhood Teams Transformation Programme.
Medway	Developing	Double handed training together across health and social care
Oxfordshire	Pre-emerging	**An understanding is needed of what each of the roles are more broadly. Health colleagues should learn about social care services and how they are driven by finance choice policies. In turn social care staff should learn more about the health driven model in particular rehabilitation and reablement and the impact for the non-regulated professionals.** A standardised outcome for therapies is something we can all use effectively. Much of the resources are directed at social work.
Surrey Heartlands	Maturing	Good process in social care.
West Sussex	Emerging	Increasingly beginning to understand health learning needs, e.g. social care practice principles to deliver rehabilitation and reablement.

4.4.2. State of AHP workforce readiness for future care

The data gathered about how ready the AHP workforce is for future care is presented according to:

1) the unique selling points and the extent to which members of the different allied health professions, in social care, have identified what they do that no one else can do;
2) how AHPs are extending their skills and knowledge to improve service efficiency and outcomes, and the extent to which tasks/ roles that other professionals perform that could be undertaken by different AHPs in social care;
3) how AHPs are enhancing the skills of others to improve outcomes – identifying the skills and knowledge that different AHPs could develop in others.

4.4.2.1. Unique selling points

The self-assessment of their unique selling points for AHPs across the South East revealed that the level of maturity for three authorities (Frimley, Kent, Oxfordshire) are emerging; for two authorities (Berkshire West and Buckinghamshire) are developing and three authorities (East Sussex, Medway and West Sussex) are maturing.

Examples of unique selling points that are at an **emerging** level of maturity:

1. OTs are trained in both mental health and physical health and are clear about their role but often have difficulty articulating it to others. They have the knowledge and skills to reduce attendance in hospital and calls into the ambulance services (Kent).

2. Physiotherapists in Home First Team are a limited resource. It is clear to them exactly what they do that is unique and what their remit is. However, they sometimes struggle to get the message across. Oxfordshire Home First the team refers on to Active Oxfordshire[37] quite a lot. Unfortunately, they do not always follow through and see what the impact has been for a service user. There is some funding to employ an activity coordinator to provide dedicated activity for inpatients. Data is collected about the impact on people deconditioning in hospital. These individuals will then be transferred to Active Oxfordshire to build on that movement for sustainable well-being and activity (Oxford).

The two local authorities (Berkshire West and Buckinghamshire) reported a **developing** level of maturity for their unique selling points and listed a myriad of activities including: all enabling, person-centred, broad problem-solving that is unique to individuals they are supporting.

Those that asserted their unique selling points are **maturing** mentioned being specialists in major adaptation, deprivation of liberty and understanding the importance of occupation.

4.4.2.2. Extending skills and knowledge of AHPs to improve service efficiency and outcomes

POTs and lead OTs/AHPs based in the South East of England were asked to consider the extent to which tasks/roles, that other professionals perform, could be undertaken by different AHPs based in social care. Under **pre-emerging** level of maturity according to comments from Oxfordshire many of the **experienced community-based OTs are frustrated because they are not permitted to carry out a basic observation on a patient when they are out in the community.**

'Half of the community OTs are not allowed to take a urine sample to be swabbed.'

They are proactively recruiting rehabilitation assistants into the Home First Team because of the shortage of OTs and physiotherapists. The premise is that a case could be assessed initially by a clinically registered professional and then the day-to-day intervention could be delegated to an assistant (see figure 3). This will require upskilling of the existing support workforce. This view is shared by colleagues in Berkshire West where the support workers work very closely with social workers, the Front Door Team and OTs. Medway Unitary Authority (UA) and health work closely together and share information about developments, e.g. hospital discharge/Home First service/double handling care.

Under **developing** level of maturity Buckinghamshire County Council recommended upskilling other AHPs to become Approved Mental Health Professionals. Oxfordshire employs coordinators who are dual skilled OTs with some social work knowledge and skills. This model is also recommended by OTs in North Kent Health, although capacity is a challenge. If there is a crisis in the community and there are no social workers available (many left during COVID and have not been replaced) an OT can support the service user. Similarly, OTs in Medway Health advise that 'OTs are well placed to take on additional skills to improve efficiency'. This is already happening in

'Under the Care Act OTs can assess for packages of care.'

Berkshire West at a **mature level** where OTs are carrying out activities under the Care Act. However, this has a notable impact on the OT workforce and the POTs state that '*OT time needs protecting and strong OT leadership is required to protect this scenario'*. Their concern is a lack of a career pathway for OTs working in adult social care unless they undertake generic social worker roles. The POTs in East Sussex and West Sussex local authorities also agree that OTs already undertake Care Act assessments and the OT in the Front Door Team is the first to make an assessment.

In Medway there is a signed agreement between social care and health which promotes support staff to work together.

4.4.2.3. Enhancing the skills of others to improve outcomes

The respondents were asked to identify the knowledge and skills different AHPs could develop in others.

Under **emerging** level of maturity Berkshire West colleagues suggested that the graded competencies of the OT Assistants (OTAs) could be upgraded, this would strengthen the aim to have just one conversation – 'say it once'. Other suggestions include:

- Social workers included in equipment training.
- Integrated working could be further taught at HEIs.

For example, in Royal Borough of Windsor and Maidenhead the OT and OTA undertake a joint assessment, and for straight forward cases the OTA will continue the treatment/rehabilitation.

Medway UA OT manager noted that the OTs in social care had offered shadowing opportunities to OTs in health who are more risk averse. The AHP Kent and Medway ICS team has provided an opportunity for teams to sign an MOU across the system to support movement of staff. Medway UA and Medway health work closely together and inform each about developments: hospital discharge/Home First/double handed care.

> *'Key to integration is OTs in health learning from OTs in social care.'*
>
> Kent and Medway

Kent County Council has launched 'Adult Social Care Connect', the new first point of contact for adult social care. The aim of Connect is to provide a joined-up, person-centred approach to support people to stay independent. The staff in Kent suggest this is an opportunity to upskill the front door staff to become therapy assistants, potentially this would 'prevent, reduce, or delay' which is central to the Care Act. Other suggestions include dementia activity coordinator reducing agitated behaviours.

There are three initiatives that the local authority-based OTs in H&IoW are **developing**:

i. Working on enhancing the skills of others and reaching out to other teams to share information about OT; what OTs do and how they can undertake joint work and support skill development.
ii. Giving talks to health teams on major adaptations, and have asked colleagues in the community to share information and attend CPD sessions.
iii. Working alongside social work colleagues and provide a lot of advice and information about a wide range of subjects i.e. utilising a strengths-based approach.

Three local authorities reported that they have a well established **mature** approach to enhancing the skills of others:

- Surrey Heartlands OTs have trained OTAs to be trusted assessors.
- East Sussex OTs have enhanced the skills of social workers employed in duty and in-reach teams. They have also enhanced the skills of other staff groups: physiotherapists, speech and language therapists and nurses.
- The West Sussex multi-disciplinary team (MDT) is supported by the OTs to prevent, reduce and delay before determining the need of the service user.

4.4.2.4. Identification of the generic skills and competencies that AHPs and other professions have which can enhance the encounter of those with lived experience

West Sussex has a **mature** approach and explained that this is a significant activity for the local authority and the POT works with the PSW to jointly produce easy to read information for those with lived experience. In July 2025 they conjointly wrote a guidance document for staff to ensure the information available to those with lived experience was clear, i.e. how to write 'good reports'. Their philosophy is to reduce any contradiction and produce just one document for 'Doris' and her family. The one document has a concise professional summary. Unfortunately, the current technology does not facilitate easy access for health colleagues. The hope is that AI will address this issue.

The other local authorities reported they are at various stages of developing initiatives to enhance the experience of those with lived experienced e.g. Berkshire West is focussing on the 'one conversation', the social worker employed in health assists with communication across the system, *'more direct conversations lead to better outcomes'*.

The POT in East Sussex explained that the cost, associated with not communicating directly with staff in other sectors, is substantial e.g. cost of a Pathway 3 bed[f] is £100k for three months. It is a significant consideration for an ICB.

> *'We only want to say it once.'*
>
> Request from service users

Discussions with service users and carers highlighted the need for the **one conversation**, they repeatedly asked that the system only requested the information once. One carer explained that the person they supported was very distressed by having to repeat their situation time and time again.

4.4.3. Joint and equitable access to learning

This section sets out the maturity of organisations to share skills and knowledge under the following sub-sections:

1) Joint and equitable access and availability of all relevant learning and development opportunities across health and social care at place-based system level.
2) Joint and equitable access and availability of all relevant learning and development opportunities across health and social care at regional system level.

[f] Pathway 3 bed- those with highest level of complex needs

3) Collaborative practice education and practice-based learning models across local authorities and NHS organisations, e.g. hybrid student placements.

4.4.3.1. Joint and equitable access and availability of all relevant learning and development opportunities across health and social care at place-based system level

There are a range of opportunities, at place-based level, for joint and equitable access and availability of learning and development programmes. H&IoW state that their offer is **developing** and there is joint and equitable access and availability of all relevant learning and development opportunities across health and social care.

In contrast, Berkshire West explained that there is **no integrated or equitable access**. Largely because there is insufficient funding with no funding for specialist OT training e.g. seating and posture training, bariatric training.

> *'The waiting time for the Oxford seating course is one year.'*

The POT from East Sussex advised opportunities should exist for all OTs across the place-based system. She suggested that there should be a clear funding structure whereby social care and health pay an agreed amount and that this could be a critical role for the regional Chief AHP.

The POT from West Sussex reported that there is robust learning and development but not always clear what is available to AHPs. The social care OTs are not excluded from the health run courses but the content and learning outcomes are not so relevant.

4.4.3.2. Joint and equitable access and availability of all relevant learning and development opportunities across health and social care at regional system level

Both H&IoW and West Sussex reported learning and development opportunities across health and social care at a regional system level. The former that their offer is for those employed at regional system level as well as those employed at place-based level. The later advised that their Moving and Handling Principles of Practice are shared with colleagues across the regional system including those in health.

4.4.3.3. Collaborative practice education and practice-based learning models across local authorities and NHS organisations, e.g. hybrid student placements

HEIs that have agreements to place AHP students in the South East region meet quarterly online. This informal group has over fifty members and is well attended. The forum is an opportunity to collaborate about practice based developments. Recently three more local HEIs: Royal Holloway, University of London; Buckinghamshire New University, and University of Health launched pre-registration occupational therapy programmes. This scenario has put extra pressure on the clinical training capacity.

The apprenticeship model enables greater flexibility and ensures that the learners spend time in the 'other' sector. This was explained by Berkshire West: *'There is an established integrated reciprocal approach between health and social care. All apprentices have at least one social care placement'.* This is not always the situation for direct entry students as the authorities have less influence on the student placements. In 2023 SfC published a guide

about optimising occupational therapy student placements across social care[38]. In the guide SfC recognised the link between learners placement experience and recruitment (Box L and 4.3.1.1).

Box L: Link between learners' placement and recruitment (Skills for Care)

'We know there are challenges for social care organisations in recruiting occupational therapists. We also know there is a link between where learners (apprentices and students) undertake their pre-registration placements and the settings they then practice in. An increase in placement opportunities is one solution to broadening awareness and experience of the role of occupational therapy within social care.'

The other significant concern is about student placement tariff, particularly for authorities that take apprentices from health or other LAs, if there is no reciprocal agreement.

H&IoW, collaborative education and practice-based learning offer, across authorities and NHS organisations, is still **developing** and they recognise that they can do more to increase local authority student placements and the development of hybrid student placements.

Similarly West Sussex's model is still **developing**. The placement is well received as evidenced by the fact that the authority won the University of Brighton apprentices' best placement award for apprentices. They recognise the challenge for students who do not have a car and have made arrangements for them to use a pool car.

Frimley ICS reported that their post-registration AHP shadowing pilot was very successful. Staff can request a shadowing opportunity with another team including across social care and health.

4.4.4: Shared skills/knowledge

In this section the respondents collated comments about, shared continuing professional development (CPD) across preceptorship, enhanced practice, advanced and consultant practice, are documented:

1) Shared CPD and training opportunities across enhanced practice.
2) Shared CPD and training opportunities across advanced and consultant practice.

4.4.4.1. Shared CPD and training opportunities across enhanced practice

The concept of enhanced practice, unlike that of advanced practice, is not well understood. CPD opportunities at this level of practice tend to evolve rather than being developed strategically (East Sussex).

In H&IoW they report **emerging** opportunities as well as the more established opportunities that are developed. For example:

- Exploring opportunities across social care and health related to proportionate care. There is a proportionate/single handed care lead in Southampton General Hospital who works closely with the local authority.
- Exploring opportunities related to intermediate care and reablement.

They also report **developing** opportunities, at a system level, that are shared with local authority colleagues through the AHP Council and Faculty. Examples include:

- community upskilling programme,
- allyship training,
- patient and public involvement training,
- proportionate care training.

Health Sciences University and Coventry University offer programmes of study for enhanced practitioners but the uptake in the South East is not known.

Berkshire West observed that currently there is no appetite for enhanced and/or advanced practice roles. However, it is likely that some staff are working at an enhanced level of practice.

4.4.4.2. Shared CPD and training opportunities across advanced and consultant practice

Other than the developments in H&IoW the local authorities did not report shared CPD at advanced level practice. In H&IoW, as mentioned for enhanced practice, there are opportunities within proportionate care (optimal/ single handed care) and rehabilitation and reablement. It is also acknowledged that there are opportunities through the AHP Faculty workstreams to develop advanced practice education and leadership pillars.

> *'Further consideration should be given to the appropriate governance.'*
>
> H&IoW

There is a paucity of consultant OTs across the South East, but where they exist they drive change and promote innovation (see section 4.4.6).

4.4.5. Integrated initiatives

The range and level of maturity of integrated initiatives, reported by the respondents, are collated under the following headings:

- Integrated services and aligned workforce initiatives at **place level**
- Integrated services and aligned workforce initiatives at **ICS level**
- Proportionate Care and Trusted Assessment across Kent and Medway
- Integrated approaches to workforce and succession planning

4.4.5.1. Integrated services and aligned workforce initiatives at place level

Four examples of aligned workforce initiatives across the South East are included below.

1. In Medway (social care and health) they report an **emerging** level of maturity and gave sharing double-handed training as an example. They also note that OTs across Medway come together to undertake projects [see the report on the Proportionate Care and Trusted

Assessment 4.4.5.3. & Annex 2]. Respondents from Medway also mentioned **mature** activities: every day there are system calls between staff, and the Single Handed Care Board, which meets weekly.

2. The lead OT from the Royal Borough of Windsor and Maidenhead described developing a competency framework for OTs and social workers which has an emphasis on integrated practice and prevention.

3. The POT for East Sussex explained that the local reablement service (staffed primarily by social care) is mature; it is jointly funded domiciliary care and therapy provision with a focus on admission avoidance and expedited hospital discharge.

4. Kent Community Hospital Foundation Trust in partnership with Kent County Council developed a new role: **Home First Support Worker** with the aim of reducing the number of daily care packages (Box M).

Box M: The new Home First Support Workers in Kent

The CEO in Kent Community Hospital FT is very proud of the Home First Support Worker (HFSW)[39] development in Kent Community Hospital. This role was jointly developed with Kent County Council and is delivered by the KCHFT and KCC health and social care partnership service. Within two weeks of appointing the first cohort of HFSWs the Trust had employed forty in this role and there was a 56% reduction in the frequency of day care required by the people they care for. Based on the success of this new workforce the Trust increased the number of HFSWs to seventy.

The HFSW is an attractive post that supports integrated care, with better pay than domiciliary care workers and a greater career structure with the potential to progress to an apprenticeship role. They have no difficulty in recruiting to these posts.

4.4.5.2. Integrated services and aligned workforce initiatives at ICS level

Three examples of mature ICS workforce initiatives: two in Kent and Medway and one in Frimley are set out below.

Kent and Medway champion Transfer of Care Hubs (Box N), it is one of the strategic priorities for this ICS. Kent and Medway has also appointed **an AHP Director of Integration** (Box O).

Box N: Better Care Funds used to support discharge

Financial support from the Kent and Medway Better Care Fund (BCF) has been used to develop '**Transfer of Care Hubs' in the county, to improve joint working across the acute, community health, social care and voluntary and community sectors in relation to discharge planning.** Weekend multi-disciplinary discharge teams have also been created to help ease flow through the system. The BCF has also been used to set up a 'Physio / Occupational Therapy (OT) in-reach and Drop and Stop Service'. This service has helped speed up discharges and has enabled an increased number of Physio / OT assessments to be undertaken in the patient's own home.

Box O: AHP Director of Integration in Kent and Medway

The Chief Executive Officer (CEO), Kent Community Health FT (Mairead McCormick) sponsored the appointment of an AHP Director of Integration in Kent and Medway. They appointed Elizabeth (Liz) Sargeant OBE to this role in East Kent. Liz was also the NHS Improvement clinical lead for integration and AHPs, and wrote many of the government **Hospital discharge and community support Action Cards**[40]**.** The OTs in Kent and Medway are very positive about this appointment

The CEO champions the role of integration lead and suggests that it is a role of the future and central to place-based care. She contends that it is essential to the NHS person-centred care initiative of 'What matters to Me'. She reported how a very successful Director of Integration had engaged the service leads and invited them to reflect on what they were doing which resulted in the people who used their services being 'caught in the middle'. She also suggested that somebody working in this type of role should have experience of working in several different sectors i.e. social care, health, VCSE (Voluntary, Community and Social Enterprise).

Frimley ICS AHP team encourage collaboration between social and health care representatives within the system at AHP Board and AHP Workforce Sub-board meetings. There are also programmes of work such as proportionate care, and discharge and flow, where all representatives are invited to attend and collaborate.

4.4.5.3 Proportionate Care and Trusted Assessment across Kent and Medway

The Kent and Medway case study site members agreed to set up a task and finish group to consider the different approaches that are taken to Proportionate Care (PC) and Trusted Assessment (TA).

Proportionate care is also referred to as single-handed care or optimised care. According to Lane and Dawson[41] from Medway Community Hospital '*Single -handed care (or reduced care handling) is a term used to describe a process in which alternative methods are used to safely move a patient with fewer carers than previously may have been used'*.

Trusted Assessment 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 SESCA's Trusted Assessor Scheme Review document [42].

There are four health and care partnerships (HCPs) in Kent and Medway (figure 11), that support healthcare providers to work more closely with local councils.

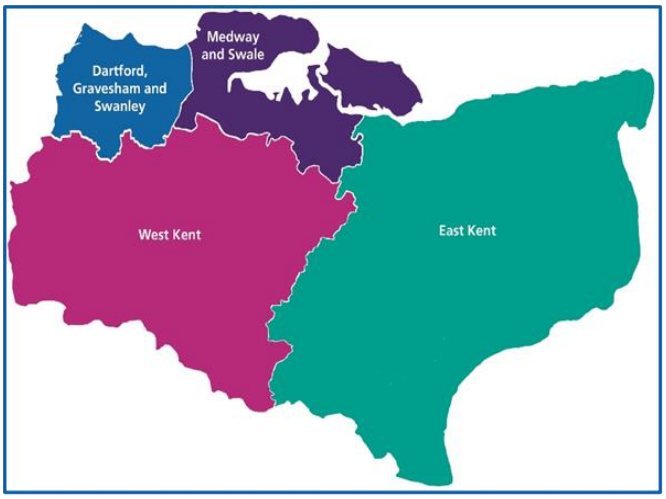


Figure 11: Health and Care Partnerships in Kent and Medway

The task and finish group had sixteen members from eight organisations across social care and health in Kent and Medway [for full list see annex 2]. Initially they were invited to comment on draft tools designed to collect data about approaches to PC and TA across the ICS. Once the data collection tools were finalised the members of the task and finish group were asked to populate the forms.

The data was reviewed and summarised under the following headings:

PC

1. Approach to governance of proportionate care
2. Model of proportionate care
3. Background to approach to delivering proportionate care
4. The staff delivering the service
5. Formal Training of staff to deliver proportionate care
6. Model of education and training of staff delivering proportionate care
7. Opportunities and Challenges of delivering proportionate care
8. Evidence of the effectiveness of model of proportionate care

TA

1. Approach to governance of trusted assessment
2. Model of trusted assessment
3. The trusted assessors
4. Formal training of trusted assessors
5. Model of education and training of trusted assessors
6. Evidence of the effectiveness of model of trusted assessment

The headline findings are presented in the table 16, further details are available in annex 2. There is concern that the current approach to PC training is largely unsustainable and there is a suggestion it could be included as part of the mandatory offer for these services.

In Kent and Medway TA development is work in progress. There is still wide disparity between adult social care, which is governed by the Care Act, and health.

Table 16: Headline findings from Kent and Medway deep dive into proportionate care and trusted assessment

Proforma Section Heading	Proportionate Care summary	Trusted Assessment summary
Approach to governance	Three out of the eight organisations reported they have a clear strategic approach to PC governance and one that it is under development. Only two respondents reported there is a clear strategic approach as to who should be trained to provide this type of care.	Five organisations provided information about the governance of TA.
The model of delivery	Seven organisations reported they provide a PC process. Reassuringly, the approach used is very similar and based on *'maximising the person's abilities and strengths … and support needs'* while '*minimising risk'*.	Four organisations reported three different models of TA: A. Provide training to all trusted assessors to enable them to assess for, and prescribe, minor equipment and adaptations. Provide training to health clinicians for them to assess for and order seating options, bathing and showering equipment. 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. Often limited information. C. Equipment provision trusted assessment is used across services within the Trust and for discharge to other organisations using the Kent and Medway Care Record.
Background to approach to using this model	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.	
The staff delivering the service	Regulated OTs are the main group who deliver PC.	Regulated OTs are the key professional group involved in TA.
Formal Training of staff	Two social care providers and three health care providers reported that they enable their staff who deliver proportionate care to be formally trained.	The responding organisations offer a variety of formal or informal training for TA.
Model of educating and training the staff	Two of the organisations reported using external training providers either A1 Training Solutions or OT4Independence, a local organisation.	i. 2-day training course provided by NRS Healthcare. ii. Competence set developed and signed off internally.

Approach to assessing these staff	Annual assessment of competencies.	Internal assessment reviewed annually.
Benefits of delivering model of care	• 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	
Challenges of delivering model of care	• 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	
Evidence of the effectiveness of the model		Two organisations reported that data is collected to help with decision making; business case development; and problem solving. It also helps to develop a greater understanding of: I. the development of the system/care processes; II. the needs and expectations of those with lived experience. It is also a better use of public funds and leads to better outcomes for the people they work with.

4.4.5.4. Integrated approaches to workforce and succession planning

Linked to workforce and succession planning is job planning. According to the NHS, Job planning is an important way to link best use of resources with quality outcomes for patients and is a useful element in service redesign[43]. This programme of work did not identify any evidence of robust OT job planning.

The POT from East Sussex suggested Integrated approaches to workforce and succession planning is definitely a workforce gap, and senior practititioners could help with workforce planning. She stated: '*it is recognised how highly skilled staff are'* and suggested to achieve intersectoral collaboration, about workforce and succession planning, requires an electronic passport of competencies, starting with newly qualified practitioners.

In H&IoW there are no formal split placements between local authorities and the NHS. However, they offer split placements within the different services where OTs work. It is also recognised that there are already opportunities in proportionate care and intermediate care/ reablement to organise cross- sector rotations.

4.4.6. Enhanced, advanced and consultant AHP initiatives

Colleagues from Medway health reported that ***'a lot of staff (regulated and non-regulated) are working above their recognised level of practice'.***

Members of the ALIGNS Buckinghamshire case study site agreed with this statement and decided that one of their actions would be to understand the **potential for Enhanced Practice to be an enabler to AHP integration** across social care and health. Subsequently it was agreed to develop a proof of concept to test the feasibility of establishing Enhanced Care Integration Teams (ECIT). For details of the approach and principles behind this proof of concept please see 4.4.8 and annex 3.

H&IoW noted that '*there are **advanced training opportunities** in proportionate care (optimal/ single handed care), reablement and rehabilitation'*. Their existing AHP faculty workstreams support the development of advanced practice within the education and clinical practice pillars[44]. However, they pointed out that appropriate governance structures should be in place. Only East and West Kent reported that they have a consultant AHP who works across health and social care. This practitioner works in neurology.

4.4.7. Digital working across social care and health

Amongst the lead OTs across the South East there are differing levels of awareness about digital working developments. It is recognised that if information is shared digitally then care is better e.g. digital rehabilitation and use of IPADs. Below are examples of digital initiatives in the South East.

The lead OT for Medway UA mentioned the Better Care Support Medway [45]. This is a self-help website which is popular with staff and those with lived experience. They also reported they tell their patients about Telecare [46] provided by Kyndi. It is a 24-hour monitoring service.

A POT based in H&IoW is leading a digital workstream within adult social care and is a member of the South East ADASS digital group.

In the Royal Borough of Windsor and Maidenhead the digital groups are integrating technology into care. For example, Magic notes and SARA tool (self service options). The latter is in collaboration with Slough Borough Council.

4.4.8. Potential new roles to strengthen integration

The Buckinghamshire case study site agreed to explore the possibility of introducing new roles/responsibilities (figure 12) that might result in enhanced integration and improve the service provided for those with lived experience. The two new initiatives are:

1. Enhanced practice and enhanced care as enablers to AHP integration across social care and health proof of concept
2. Extent to which volunteers can support the people who are transferred from the acute setting into community settings with support from social care teams.

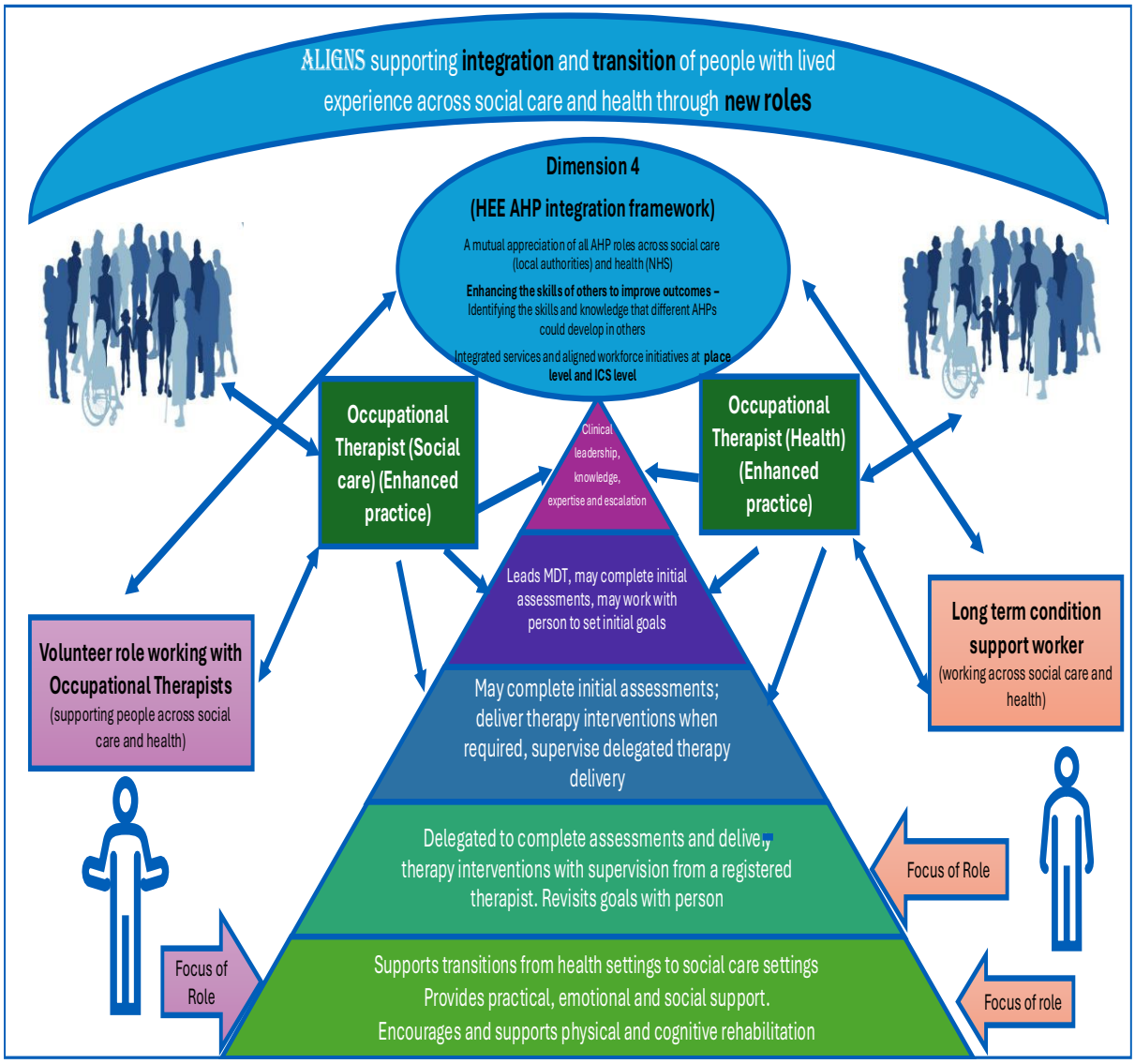


Figure 12: Potential new roles/responsibilities

4.4.8.1. Enhanced practice and enhanced care as enablers to AHP integration across social care and health proof of concept

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:

i. Enhanced Care Integrated Team (ECIT)
ii. ALIGNS career development and education development framework

i. Enhanced Care Integrated Team (ECIT)

The proposed principles for the concept of an ECIT (figure 13) were drawn from the principles of two existing care models (table 17):

1. Enhanced Supportive Care (ESC) [47,48,49]
2. Enhanced Health in Care Homes (EHCH)[50]

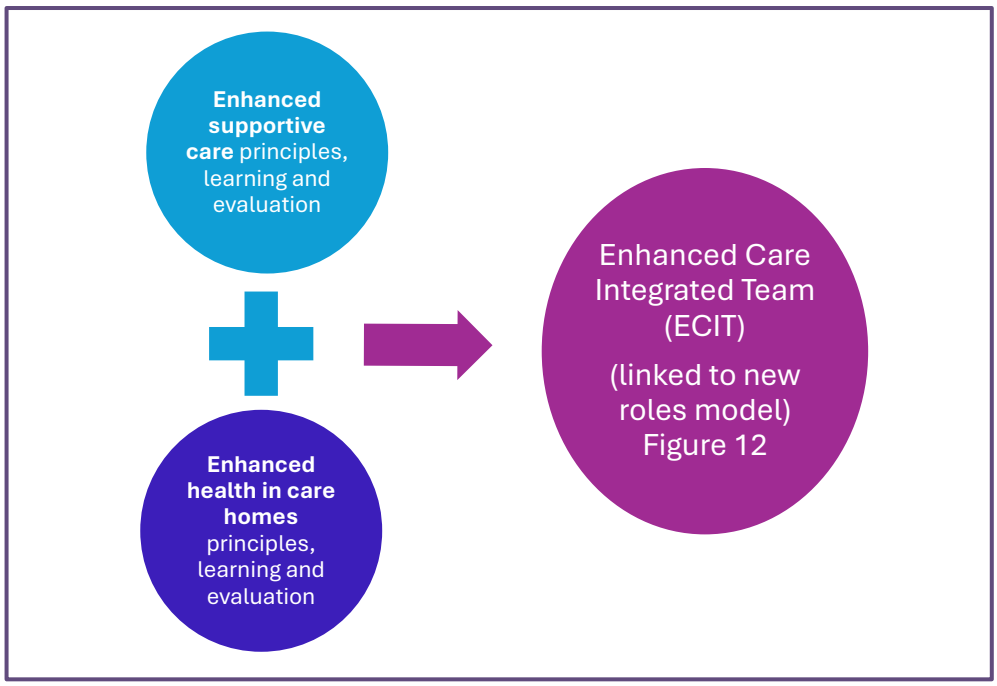


Figure 13: The concept of an Enhanced Care Integrated Team

Table 17: Overarching principles for Enhanced Supportive Care and Enhanced Health in Care Homes

Enhanced Supportive Care (ESC)	Enhanced Health in Care Homes (EHCH)
• Earlier involvement of supportive care services • Supportive care teams that work together • A more positive approach to supportive care • Cutting edge and evidence-based practice • Technology to improve communication • Best practice in integrated care	• Personalised care: *'What matters to me?'* • Co-production and collaboration • Quality: Using research, innovation and evidence-based practices to drive and sustain improvements • Strong collaborative leadership: local, regional and national level • Digital technology as a key enabler

These established principles were tested, in Buckinghamshire, with three clinical teams with responsibility for reablement, rehabilitation, independence and community support:

1. Rapid Response and Intermediate Care which includes Urgent Community Response
2. Home Independence
3. Home First

The objective was to understand how the work of the three clinical teams aligned to the principles listed in table 17.

In addition, the ECIT development group considered:

- Alignment with the development of Integrated Neighbourhood Teams[51], Neighbourhood Health Guidelines[52] and Care Transfer Hubs[53].
- Supporting implementation of the NHSE Community Rehabilitation and Reablement model[54].
- The value of professionals, in an ECIT, working at an enhanced level of practice as informed by the Occupational Therapy Enhanced Practice Schema[55] and the associated pathway descriptors including:
    - Community-based rehabilitation pathways (across all sectors),
    - Urgent and emergency care pathways to support people to remain at home (across all sectors),
    - Primary care, inclusive of community-based proactive care and enhanced support in care homes,
    - Social care.
- Recognising the value of enhanced care workers[56] being integral to an ECIT in supporting:
    - continuity of care,
    - reconditioning and recovery,
    - engagement,
    - de-escalation

  and promoting independence and increasing productivity and efficiency.

ii. ALIGNS career development and education development framework

ALIGNS career development and education development framework

The case study site also explored whether an ALIGNS education development and career education framework could be developed based on the very successful NHSE national programme called the Aspirant Cancer Career and Education Development (ACCEND) programme[57] where the purpose is:

'To provide clear and transparent guidance and direction on the knowledge, skills and capabilities required by all support workers, nursing associates, registered nurses and allied health professionals who care for people affected by cancer in generalist and specialist cancer services and roles as part of multi-professional teams across the four UK nations.'

The proposal is that an **ALIGNS career development and education development framework** is developed for AHPs with a focus on integration. The framework would include three components as set out in figure 14.

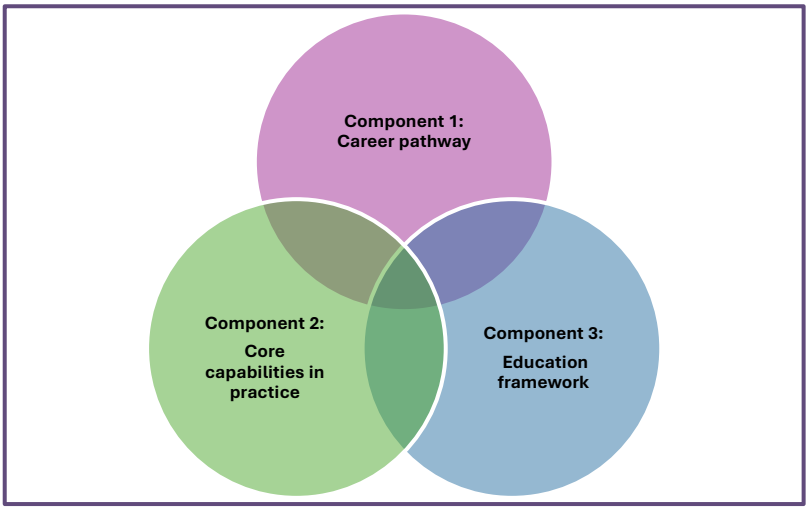


Figure 14: Proposed ALIGNS career development and education development framework

This proposed ALIGNS career development and education development framework accords well with dimensions 3 & 4 of the AHP integration framework (figure 15) and the anticipated benefits are listed in table 18.

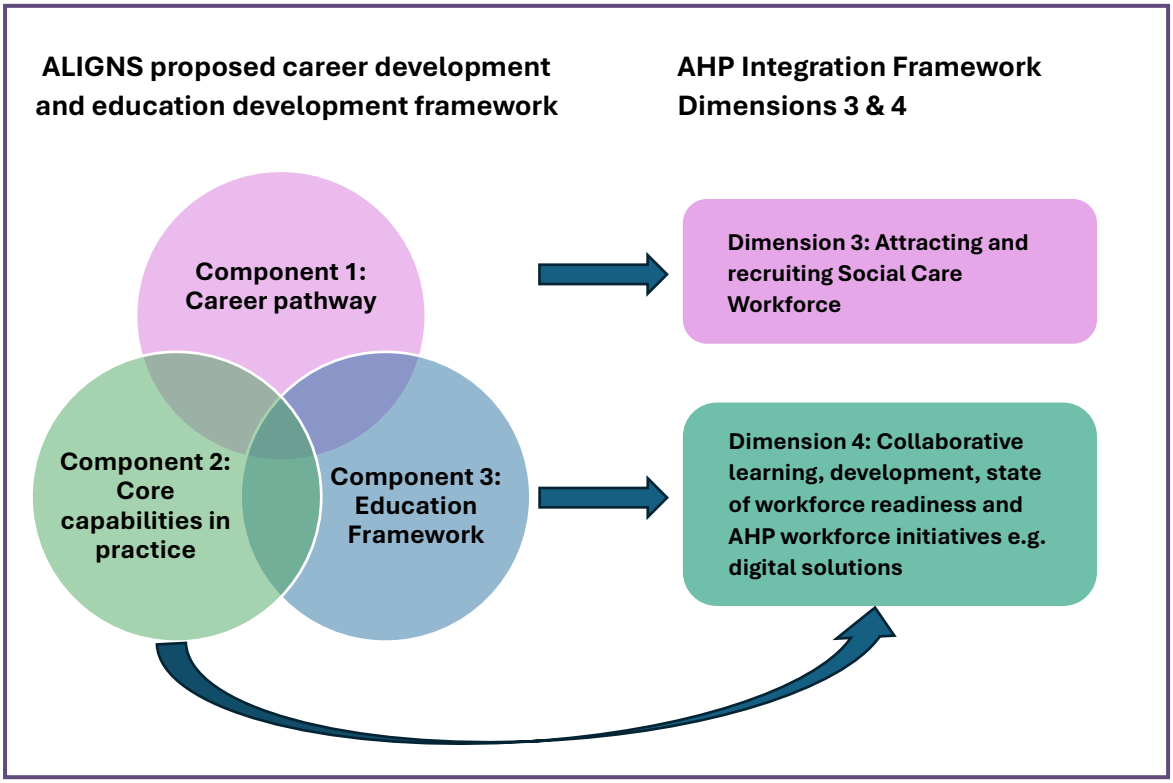


Figure 15: Proposed ALIGNS career development and education development framework mapped to the AHP Integration Framework

Table 18: The benefits of a proposed ALIGNS education and career development framework

Attract Allied Health Professionals into a career in social care and health with a focus on AHP led integration.
Develop and promote a nationally agreed, multi-level, multiprofessional education framework and career pathway for AHPs aspiring to work at all levels of practice (supportive, assistive, pre-registration, enhanced, advanced, consultant) which supports the delivery of 'One Workforce'.
Enable employers to deliver high quality services to local populations, support workforce transformation, and promote health and wellbeing of staff.
Develop, design and provide access to contemporary pre- and post-registration education, learning and development opportunities and placements that will underpin the knowledge, skills and competencies required for their role/service, wellbeing and career aspirations.
Develop AHP workforce capabilities that are fit for the future within integrated social care and health teams that are experiencing increased demand and complexity, rapid change and advancements in how support and care are delivered.

The findings

A. ECIT

- There are a number of limitations when considering a proactive ECIT care model e.g. bed pressures and the need to focus on discharges rather than prevention of admissions.
- Some of the evidence used to inform the ECIT proof of concept was less clear when tested in the three teams, including:
  - true co-production and collaboration with those with lived experience;
  - a lack of integrated IT systems to be able to see and input into a patients care record;
  - teams were either hosted by health or social care and were not fully integrated across social care and health. Although, there was evidence that teams worked closely together to support patients with different needs.
- Team leadership was either AHP or social worker led. In one team the lead for the team had worked as a social worker in the local council for over 10 years before moving to lead the current team hosted by the acute NHS Trust. It was encouraging to hear that the teams were part of ongoing discussions about their involvement in the emerging Integrated Neighbourhood Teams.

B. ALIGNS career development and education development framework

- Different competency documents and different frameworks reported as being used in teams for different staff.
- Levels of practice of staff is not commonly used, particularly in social care as this concept originated in health. The only levels of practice mentioned were supportive, assistive and registered staff. There was also evidence from previous community readiness work[58] where the meaning of terms such as enhanced practice were reported as not well understood. In a recent national survey about ACCEND[59] 30% of the 2000 respondents advised they could identify their level of practice.
- Enhanced care workers were not included in any of the teams. However, they could be considered as these are new roles that have been piloted recently by SfC[60].

- There was limited evidence of core capabilities across leadership and collaborative practice; developing evidence-based practice and improving quality; service evaluation, and educating and developing themselves and others. There was some evidence of career pathways for staff. However, to ensure equity of provision the pathway should be clearer.

Suggestions for next steps

1. Co-production and collaboration with those with lived experience should extend beyond the use of feedback surveys. People with lived experience could have a greater role in supporting and advising on the design, development and delivery of the services provided by the teams. Patients are asked, multiple times, for information rather than simply 'saying it once'. This needs to be considered in any future service developments.
2. Use research findings, innovation and evidence-based practices from previous work to drive and sustain improvements across social care and health teams.
3. The access and use of IT systems to both view and input into peoples' health and care records across social care and health is critical for all teams and should be applied more to enhance efficient and productive ways of working.
4. The use of one multiprofessional competence and capability framework, including an education framework and career pathways, across NHS and social care, which includes levels of practice to inform skill mix in teams should be considered. The ACCEND framework and associated programme of work is an example of how the principles from this proof of concept could be used to strengthen AHP led integration across social and health.

For further details please see annex 3.

4.4.8.2. Extent to which volunteers can support the people who are transferred from the acute setting into community settings with support from social care teams.

The Head of Faculty of Volunteering and Community Partnerships, Buckinghamshire Health and Social Care Academy worked with the Academy Workforce Programme Fellow and the ALIGNS Buckinghamshire case study site to ascertain the extent to which volunteers can support OTs, therapy support workers and the people who are transferred from the acute setting into community settings with assistance from social care teams. Key objectives for ALIGNS was to **create a new volunteer role, with agreed responsibilities; evaluate this role and assess its sustainability.**

Three new volunteer roles were designed with AHPs, informed by insights from people with lived experience. This generated new knowledge about how volunteers can support the effectiveness of AHP interventions. The new roles are:

- ALIGNS volunteer role 1 – **Rehabilitation support volunteer**: Volunteers to help OT and Physiotherapy teams in an inpatient hospital environment for service users needing additional support before transitioning home.

- ALIGNS volunteer role 2 – **Wellbeing check-in volunteer**: Volunteers to help integrated teams supporting service users transferring from acute hospital to community/home settings.
- ALIGNS volunteer role 3 – **Rehabilitation at home volunteer**: Volunteers to help physiotherapy and OT teams by supporting service users to complete prescribed rehabilitation activities once transferred from acute to community settings.

The developed role descriptors are included in Box P.

Box P: Volunteer role descriptors

Rehabilitation support volunteer

We are seeking volunteers to help enhance the service user experience and complement and support the work of paid members of staff. Specifically, we are looking for people interested in supporting Occupational Therapy and Physiotherapy teams in an in-patient environment, whose role is to help service users transition from the hospital back home or into a community setting. Each volunteer will be supported and provided appropriate training and an induction before starting their role. Volunteers are supervised by a member of staff, and in some cases, will also have the support of a volunteer 'buddy'.

Wellbeing check-in volunteer

We are seeking volunteers to help enhance the service user experience and complement and support the work of paid members of staff. Specifically, we are looking for people interested in supporting Allied Health Professionals who work as part of an integrated team, supporting service users to transfer from hospital to community settings. Each volunteer will be supported and provided appropriate training and induction before starting their role. Volunteers are supervised by a member of staff, and in some cases, will also have the support of a volunteer 'buddy'.

Rehabilitation at home volunteer

We are seeking volunteers to help enhance the service user experience and complement and support the work of paid members of staff. Specifically, we are looking for people interested in supporting Physiotherapy and Occupational Therapy teams to help service users complete prescribed rehabilitation activities once transferred from acute to community settings.

To enable these roles to be developed and implemented the following were identified

1. **Existing partnerships with representation from social care, AHPs, and the voluntary sector.**

This was evidenced through the contributions of the Volunteer and AHP Faculties of the Academy to support delivery of the key outcomes and outputs through insight gathering and co-design activities.

2. **Robust organisational policies and procedures for involving volunteers**

Having an established volunteering programme with induction and onboarding processes in place provides a framework to enable exploring and developing new roles for volunteers.

3. **Capacity and capability to engage in co-production with people with lived experience**

Many different methods of engagement were required to gather insight from people with lived experience (virtual, in-person and postal options); the capacity, capability, and experience of the project team enabled accessible opportunities to engage with people with lived experience to inform the creation of new volunteer roles.

4. **Existing relationships and engagement with adult social care teams**

This is essential as it enables exploration, co-design and implementation of new roles to lead integration through a social care lens.

The full end of project Case Study report can be found here.

Sustainability of the volunteer role

The sustainability of the proposed volunteer role was assessed using the NHS sustainability model[61]. The sustainability model has three facets: Process, Staff and Organisation. It can be used at the outset, during, or at the end of an initiative to identify sustainability and areas for teams and organisations to focus on. Each facet has a number of criteria against which sustainability can be assessed. The maximum total score for each facet is provided in the tool, as is the maximum score for each criterion, e.g. for staff the maximum aggregated score is 52.4 and for the clinical leadership criterion it is 15.0. The calculated score for each criterion for the volunteer role is shown in figure 16.

The portal diagram (figure 17) illustrates the volunteer role scores compared to the maximum scores in the tool. The volunteer role scores reflect the stage of development of this initiative. This diagram highlights where the maximum focus should be to ensure this initiative is sustainable e.g. **Process**: - adaptability of the process, the effectiveness of the system to monitor the progress of the initiative and **Organisation** in particular infrastructure to support the role. It would be prudent for the tool to be used again in several months to understand the sustainability again based on any further work undertaken.

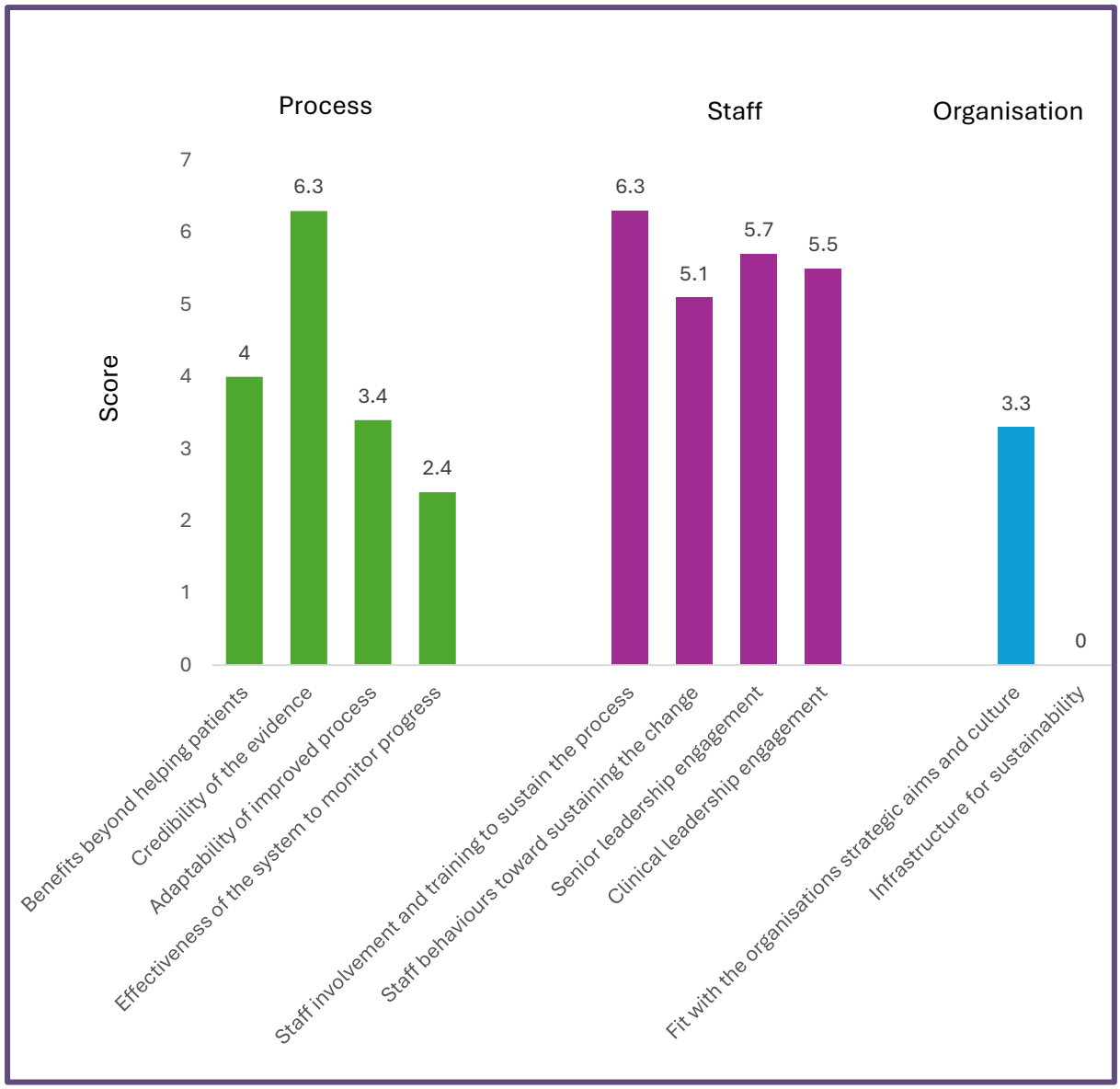


Figure 16: ALIGNS Volunteer workstream scores for a) Process b) Staff c) Organisation using the NHS Sustainability Model

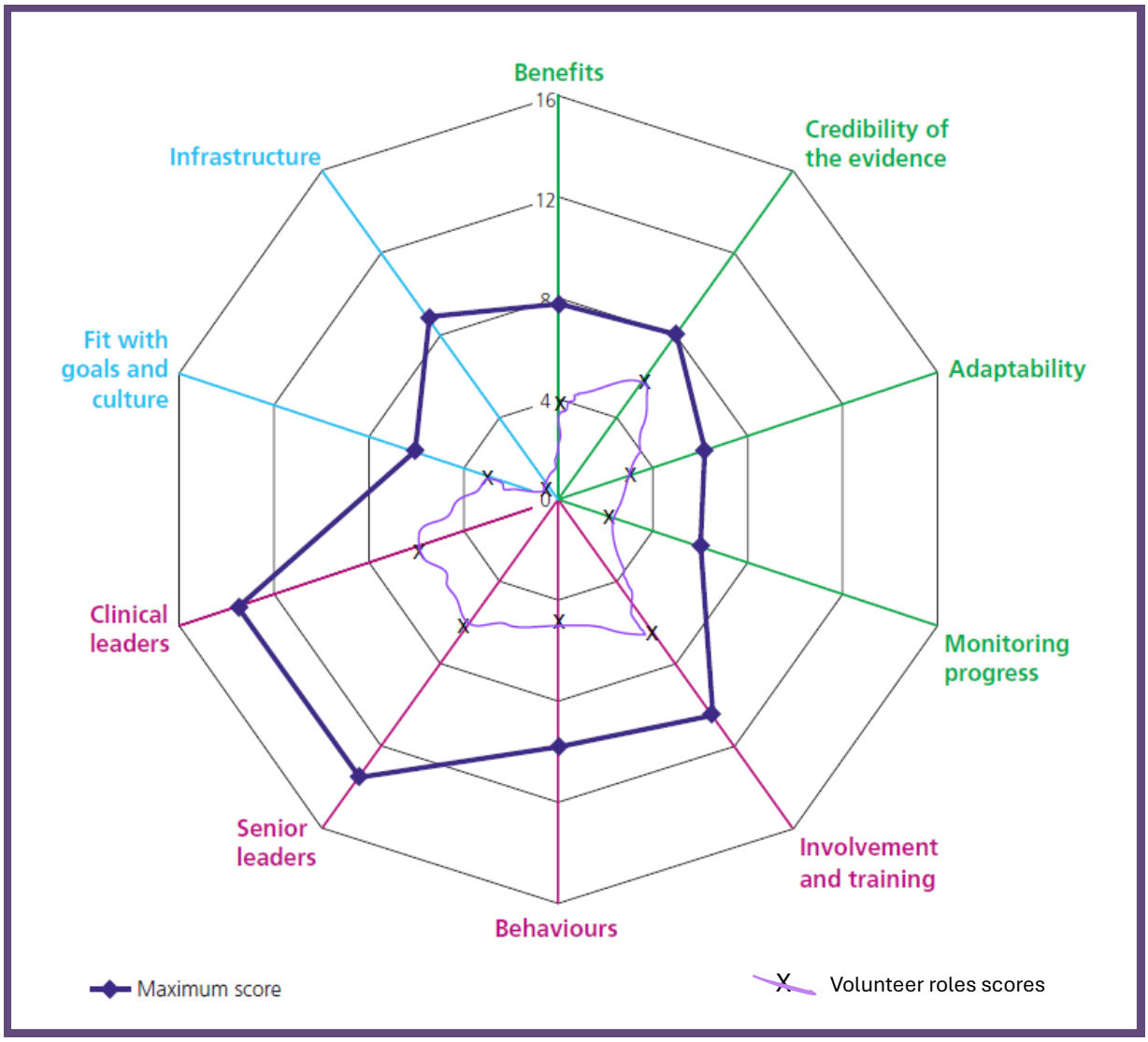


Figure 17: Portal diagram for volunteer roles

Dimension 5: Culture, climate and ways of working together

According to TLAP (Think Local Act Personal) 2025 *'Language shapes the way we think about and behave in health and social care. The words we use can invite people in or exclude them altogether. Too often, the language of care and support feels like it belongs to systems and processes, not people. It can be full of jargon, acronyms, and terms that don't reflect what it means to live a good life.'* [62]

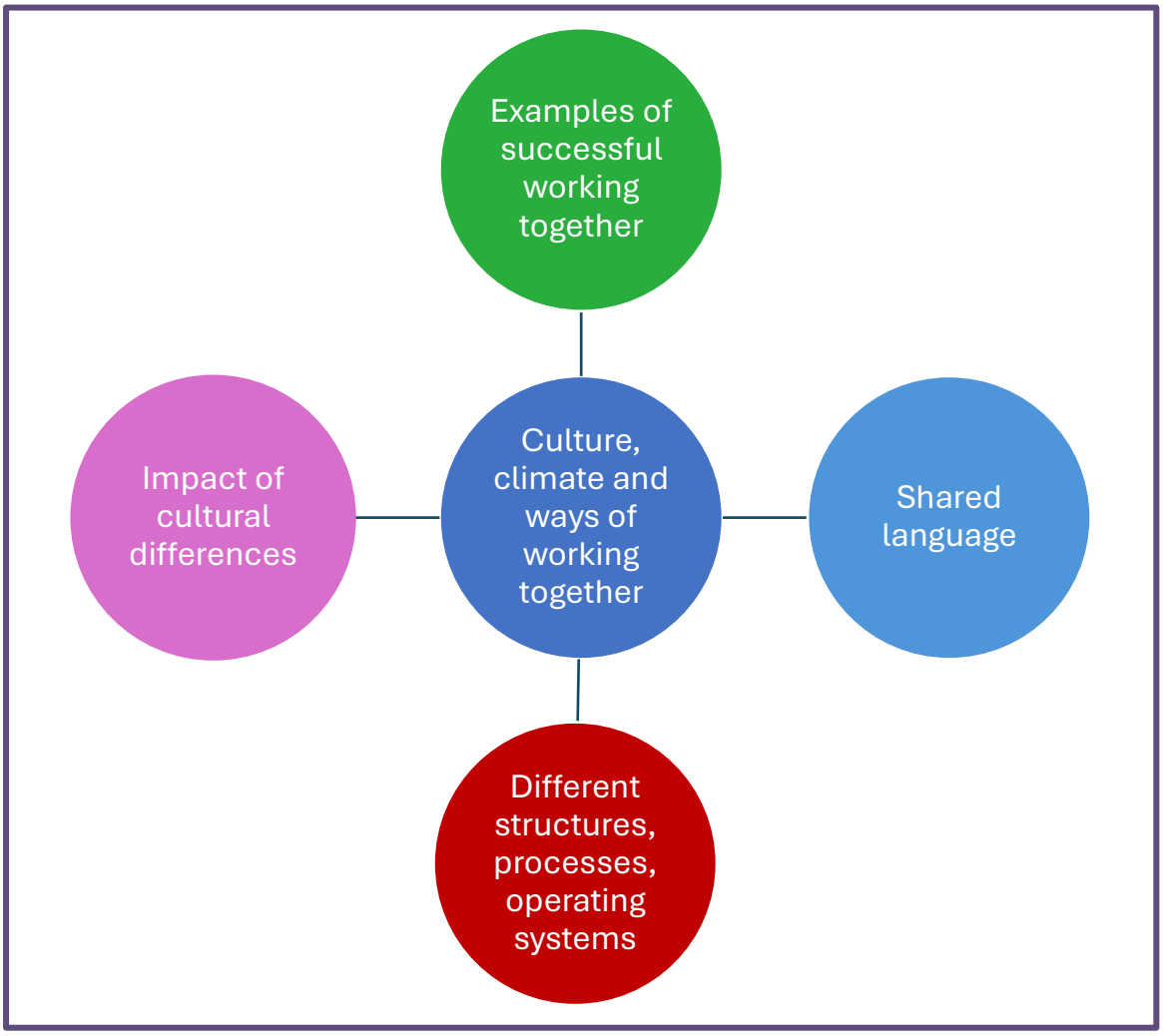


Figure 18: Dimension 5 sections

In the AHPs leading integration framework there are fifteen suggested activities relating to culture, climate and ways of working together (appendix 8). The authors have clustered these activities under four headings and grouped the headings into a fifth dimension as shown in figure 18.

The four headings are:
4.5.1. Shared language
4.5.2. Different structures, processes, operating systems
4.5.3. Understanding the impact of cultural differences
4.5.4. Examples of successful working together

Included in this report is the overview of the **ALIGNS: Strengthening the voice of Occupational Therapists in integration workshops (section 4.5.5.)**

An overview of self-reported level of maturity for dimension 5: **Culture, climate and ways of working together** is illustrated in table 19. The organisations listed either relate to place based-partnerships, e.g. Berkshire West; a local authority e.g. East Sussex LA, or an ICS e.g. H&IoW.

Table 19: Dimension 5: Culture, climate and ways of working together self-reported level of maturity

Organisation	Self-reported level of maturity			
	Pre-emerging	Emerging	Developing	Maturing
Berkshire West				
Buckinghamshire				
Frimley Health				
Hampshire & Isle of Wight				
Kent				
Medway				
Oxfordshire				
Surrey Heartlands				
East Sussex LA				
West Sussex LA				

4.5.1 Shared language

4.5.1.1. Language differences

All respondents recognise that there are language differences between social care and health. The extent to which they try to manage this difference ranges from pre-emerging to mature as shown in the table 20.

Table 20: Language differences between social care and health

Council/local authority/place	Level of maturity	Comments
Berkshire West	Pre-emerging	There is no shared language, this complicates what each other does and impedes progression of work. Example: NHS employment Bands/ social care grades of workforce.
Kent County Council and Medway Unitary Authority	Emerging	The TLAP language hub is very helpful[62]. The staff who work in health are very influenced by the medical model e.g. there is a big difference in the language used for single handed/proportionate care. **Different language does not mean different ways of working.** Patient stories are key, whatever the language differences. The different employment terms e.g. KR10/Band 6 does not help the people with lived experience/patients.
Oxfordshire	Emerging	The junior staff in social care and those working in health find it particularly difficult.
	Developing	Staff in social care understand the language used in health more readily than their counterparts in health understand terms used in social care. Staff who have worked in health previously and are employed in social care find it much easier.
H&IoW	Developing	Both health and social care AHPs recognise that there are separate languages and are trying to bridge the gap.
Buckinghamshire	Maturing	Complete acceptance of differences, understand across health and social care AHPs what is meant e.g. patient/service user etc. It is not a barrier for staff but can be a problem for the residents.
East Sussex	Maturing	Differences are acknowledged and staff seek clarification. This was important to the CQC who sought assurance about legal literacy and language, e.g. people we work with.
West Sussex	Maturing	This is one of the first things we discuss when setting up a new project.

4.5.1.2. Opportunities to use shared language have been identified

The staff from the local authorities reflected on recent opportunities they have had to use shared language. Five of the six respondents, who provided a comment, judged the level of maturity for using shared language to be **developing or maturing**. Only Berkshire West reported that it is still pre-emerging. They explained that '*a recent MHRA' (*Medicines and Healthcare products Regulatory Authority) related event '*presented an opportunity to use shared language and collaborative approach to agree a common risk assessment. However, agreement of what is needed internally, didn't match so it didn't happen. Social care wanted more detail: health had different aspects of the pathway, e.g. hospital discharge, reviews'*. They recognised that this example is not language specific although language was part of the scenario.

The five authorities who reported their level of maturity is developing or maturing cited language specific examples (table 21).

Table 21: Level of maturity of using shared language

Authority	Example of shared language
Developing	
Oxfordshire	Example of best practice: The Home First team co-produced a patient discharge leaflet with the acute, voluntary sector, and end users in different ward settings. The leaflets were carefully reviewed across the system. Shared systems support encourages the use of the same language.
Kent County Council	Proportionate care and Trusted Assessment development (see section 4.4.5.3).
H&IoW	Strengthening the AHP (OT) voice across health and social care, particularly through cross organisational programmes like proportionate care, supports the development of a shared language. This can be further supported by increased exposure through practice placements and rotations/secondments.
Maturing	
Buckinghamshire	Common/shared language is not required, there is an understanding of each other's language. Terms are used interchangeably and comfortably.
West Sussex	Pan-Sussex rehabilitation and reablement group uses shared language. The terms: • person-centred • needs-led • strength- based are being used more and more.

4.5.2. Different structures, processes

In this sub-section the authors report the following:

- Understand how health and social care services fit together
- Understand how different people, teams or organisations interconnect and interact
- Understand the different operational processes used in social care and health organisations
- Recognition of the implications of the different values held by those who deliver the service
- Clear understanding about how complex connections across the health and social care economy affect the productivity and efficiency of the system
- Clear understanding of the impact of a rigid approach to care

4.5.2.1. Understand how health and social care services fit together

Respondents from ten organisations commented. Most of them advised that the level of understanding is still developing. Although the level of maturity ranged from emerging to maturing as shown in table 22.

Table 22: Level of maturity about how health and social care services fit together

Council/local authority/place	Level of maturity	Comments
Frimley	Emerging	Discussions at the OT collaborative meetings include new ways of working. The 'collaboration plus' provides learning, for providers, about each other.
Kent County Council		The level of understanding is determined by the level of practice/experience.
H&IoW		Different structures for those who deliver and use the service can result in different approaches - medical model/social model.
West Sussex		Interact with Sussex Community FT rather more than local council staff.
Berkshire West	Developing	There is a deep understanding and influence in complex landscape of how services fit together, and operational processes are used in social care and health organisations, and how this impacts care: • good working relationships and communication cross-organisations helps to break down barriers.
Buckinghamshire Council		Need more of an MDT approach to address risks.
Kent County Council		There is a high-level understanding for senior staff, less so for those with patient contact.
East and West Kent (health)		The staff work together to discuss how best to manage a patient/those with lived experience.
East Sussex		Therapy teams do understand e.g. the difference between rehabilitation and reablement.
West Sussex		Increasingly understanding the need to align the rehabilitation and reablement care pathway from acute to community.
Buckinghamshire Healthcare Trust	Maturing	In AHP/therapies there is an understanding. However, roles not clearly understood by other professionals (non-therapists), nor the public.
Oxfordshire		Oxfordshire Way[63] and joint commissioners who are health and social care.

4.5.2.2. Understand how different people, teams or organisations interconnect and interact

Across the region the self-reported level of maturity, about how well staff understand how different people, teams, organisations interact, is emerging or developing:

- emerging- Berkshire West (see Box Q), East and West Sussex
- developing: Buckinghamshire, H&IoW, Oxfordshire

Box Q: Berkshire West's view on level of understanding as to how different teams interact

'The level of maturity is emerging, although those who work in mental health services have a greater understanding. This is because the links between the teams are stronger. This reduces duplication, there is a clear understanding of the roles and who to refer to. The enabler to strengthen the understanding is good interpersonal relationship between the teams.'

4.5.2.3. Understand the different operational processes used in social care and health organisations

The statutory guidance from the DHSC (updated 2024) about hospital discharge and community support[64], sets out how health and care systems should support the safe and timely discharge of people who no longer need to stay in hospital. This guidance, which requires both the NHS and social care to **jointly develop** new ways of working on the discharge of patients from hospital, should lead to new ways of working. The current position is that the level of maturity for organisations in the South East is still emerging (Box R) or developing/maturing (Box S).

Box R: Examples of emerging level of understanding of different organisational processes

Social care specific processes are less well understood by health colleagues than vice versa (Oxfordshire).

The AHP team are a conduit for this. We have an understanding of different organisational processes and keep that under consideration when working in the world of transformation (Frimley).

The situation in adult social care is different because social workers will have set the scene. E.g. in the UK practice is discriminatory - Syrian refugees who have lived in large groups do not fit into our UK houses. AHPs are often the last resource available to help them (East Sussex). We are listening and want to understand. The rehabilitation/reablement community of practice report by Professor John Bolton[64] led to pan Sussex feeding into health major services review focus on rehabilitation and reablement, and emerging and urgent care.

Box S: Examples of developing/maturing level of understanding of different organisational processes

Refer patients on to Community Complex Care Team, a conduit to social work support. The OTs refer on to adult social care for adaptations (Buckinghamshire).

A greater understanding is developing through joint work and discussion at AHP council, faculty and working groups (H&IoW).

Staff have a high level of awareness (Oxfordshire).

4.5.2.4. Recognise the implications of different structures for those who deliver and use the service

At the heart of the different structures are the models of care: medical model vs social model of care. This results in different structures for those who deliver and use the service (H&IoW - Emerging maturity).

Critically the lack of visibility, access to each other's data systems and lack of joint data often lead to those with lived experience repeating information and/or staff duplicating assessments. Canterbury Christ Church University expert service user /carer group reported that they are always being asked to retell their story.

> *'We only want to say it once.'*
>
> Plea from service users and carers.

There are ongoing concerns that things can get missed as one member of staff in sector A believes the other in sector B has completed an intervention. It is essential to be aware of the other sector's demands (Berkshire West – Emerging maturity).

The different structures can be very confusing for those who use the service and those who deliver the service (East and West Kent & Oxfordshire – developing maturity).

4.5.2.5. Clear understanding about how complex connections across the health and social care economy affect the productivity and efficiency of the system

Throughout this project staff have reported that the IT systems (local health and social care) do not interact, resulting in different recording requirements.

The different funding flows (H&IoW – emerging; East and West Kent – developing) also present a complex challenge. The Transfer of Care Hubs (TOCH) help with efficiency, but capacity in each service is a limitation. However, East Sussex (maturing) observed that if the TOCH decisions are not correct it is a cost to the system and to the health of an individual as more complex problems are escalated to the ICBs. Similarly West Sussex noted that staff in social care are very aware of complex situations and resolve problems on a daily basis.

4.5.2.6. Clear understanding of the impact of a rigid approach to care

The staff are very clear that the existing rigid and often polarised approaches to care have a significant impact on service users' care. Furthermore, a rigid approach results in unmet and escalating needs, which in turn puts pressure and additional financial burden on both health and care systems.

Colleagues in H&IoW suggest that ***'more visibility of information across the system would help. Having IT systems that talk to each other to provide relevant information would prevent duplication and better working together. More networking and understanding of roles/how we could work together is needed'.***

4.5.3. Understanding the impact of cultural differences

According to the Institute of Directors an organisation's culture 'consists of shared values, beliefs and assumptions about how people should behave and perform at work, and how decisions should be made' [66]. In 2025 the Care Quality Commission (CQC) updated its guidelines about culturally appropriate/culturally competent care [67] and considered three CQC regulations: person-centred care, dignity and respect, and the need for consent. In this sub-section the authors report the following:

- AHPs understanding of their impact on culture across social care and health
- Whether cultural audits are routinely undertaken
- Whether AHPs recognise the different cultures
- Implications of different goals and values
- Recognition of the implications of the different values held by those who deliver the service
- AHPs have a clear understanding about which issues affect decisions across the system

4.5.3.1. AHPs understanding their role in their impact/effect on culture across social care and health

For many this is not a concept that has been widely considered. Where there are TOCHs the impact of roles on culture is beginning to be recognised (Kent). Similarly, according to West Sussex opportunities must be created to explore this notion: '*Crawley and Chichester are good at this'*.

H&IoW reported that a greater understanding is developing through the joint work and discussion at AHP Council.

Oxfordshire and Buckinghamshire Councils are clear that for their organisation there is ongoing mature activity: '*OT team culture is very tight with a good handle on learning and development and the impact they have'* (Buckinghamshire). The Home First Team understands their impact across the sectors (Oxfordshire).

4.5.3.2. Cultural audits have been undertaken in both health and social care

Across the South East there are very few reported cultural audits. The three councils who provided information stated the approach was mature:

- Berkshire West collects data about travellers and the Roma community.
- Buckinghamshire Council recently undertook a culture and diversity audit. Subsequent to this audit the Council has implemented culture and care plans to improve cultural competence.
- Oxfordshire Council noted that the Council CQC inspection highlighted health inequalities because there are ten areas of deprivation in Oxfordshire (life expectancy/ benefits/job opportunities)

4.5.3.3. Recognise the implications of the different cultures across social care and health

It is difficult for staff to recognise the implications of the different cultures across social care and health because this concept is very dependent on an individual's work and life experience. It is likely that staff employed in health will have a clearer understanding, as this will have been covered in the pre-registration programme. The self-reported level of recognition is set out in table 23.

Table 23: Level of maturity about the implications of the different cultures

Council/local authority/place	Level of maturity	Comments
H&IoW	Emerging	There is some understanding and discussion about cultural differences although no formal audit has taken place within our system for AHPs.
West Sussex		Beginning to understand the implications for those we support, and the journey they support (the cared for and carers).
Berkshire West	Developing	Apprentices are more likely to understand this better than direct entry students because they have a better social care experience.
East and West Kent health		Ensure all patients have the opportunity to express their cultural preferences e.g. female staff, translation service, appointment booked by telephone rather than a letter, pictorial exercises to help explain.
Buckinghamshire	Maturing	The Buckinghamshire Health and Social Care Academy is central to developing this recognition e.g. The Academy Conference and Opportunity Bucks [68].
Oxfordshire		The Oxfordshire health sector has signed up to be a Marmot place including health inequality/ cultural diversity [69].

4.5.3.4. Recognise the implications of the different goals for those who deliver and use the service

Representatives from H&IoW reported that '*acute health settings are often focussed on discharge and admission prevention whereas social care is focussed on people managing independently, in the least restrictive setting, with the lowest care requirements. A focus on a strength-based approach and outcomes for the individual will bring different goals for those who deliver and use the service together'* (Emerging maturity).

In Sussex the POTs appreciate that health goals are restricted and that the OTs in health should work more closely with those in social care to understand more fully the different goals. In Oxfordshire they report that their approach is mature. The Oxfordshire Way has clear goals, and clear Key Performance Indicators for services involved in hospital discharge. They hold monthly meetings to review trends, reduce Pathway 2[g] bed usage.

[g] ***Pathway 2:*** Discharge to a Community bedded setting with dedicated health and/or social care and support, including bed-based intermediate care on a time-limited, short-term basis for rehabilitation, reablement and recovery in a community bedded setting (bed in care home, community hospital or other bed-based rehabilitation facility).

4.5.3.5. Recognition of the implications of the different values held by those who deliver the service

There is recognition by both H&IoW and East Sussex that this is where the services are more closely aligned and come together. The values of supporting a person and the principle of non-maleficence are the same across the sectors, but how they are achieved can be different because of the specific service demands and pressures that dictate priorities.

4.5.3.6. AHPs have a clear understanding about which issues affect decisions across the system

H&IoW observed that beliefs and values of each system can be different, each system can feel it is the others responsibility. Even though the systems share the same end goal which is the best outcome for the individual using the services.

Frimley reported that they have a clearer understanding (developing). Their structure of an AHP Board, an AHP Workforce sub-board and OT collaborative provides '*forums in which representatives from all providers can bring issues/ideas and we work in collaboration to determine potential impact in other areas of the system'*. Similarly West Sussex noted there is a developing understanding amongst the OTs working in the community and the Front Door Teams.

Buckinghamshire cited an example of their mature understanding as shown in the Box U.

Box U: Buckinghamshire's understanding about issues that affect decision making

There are inappropriate referrals from the ambulance service. Meetings with ambulance and police service take longer to triage. It is important these organisations can differentiate between a safeguarding concern and a wellbeing concern. **Incorrect referrals have a risk of missing something more pertinent.**

4.5.4. Examples of successful working together

4.5.4.1. Relationships are being built to recognise other organisations' passions and concerns

Building effective relationships that enable staff to recognise other organisations' passions and concerns is central to successful integration. Across the South East these relationships are still developing. The POT from West Sussex explained that staff can become 'battle hardened' and she recognises, through the work that she is leading on in the council, that **there is a significant education role for social care if integration is to be achieved**. In Buckinghamshire they are also addressing this and through the safeguarding adults review they have set up learning events which are helping to build these key relationships.

In H&IoW they are developing these relationships; the local authority colleagues have a strong voice in the AHP Council and are continuing to understand both health and social care concerns and opportunities. East and West Kent health sector report that relationships with

social care are being built, but that they do not know all the social care concerns, although they are aware of the lack of care managers.

4.5.4.2. Interpersonal and organisational understanding is used to persuade and build collaboration between Social Care and Health

There was relatively little comment about how interpersonal and organisational understanding is used to persuade and build collaboration between social care and health. In Sussex they have established a Sussex wide OT community of practice which has good representation from health and social care. In Buckinghamshire the Health and Social Care Academy provides many opportunities for collaboration particularly through the Faculty of Allied Health Professionals and the Faculty of Social Work and Social Care.

4.5.4.3. Other examples of successful cooperation between social care and health

In table 24 below are three examples of successful cooperation, between social care and health, in the South East.

Table 24: Successful cooperation between social care and health

Council/local authority/place	Level of maturity	Example of successful cooperation
West Sussex	Developing	There has been recent work on the risk assessment, led by Sussex Community Foundation Trust, working with Brighton and Hove City Council, and West Sussex County Council. Representatives from these organisations have come together to work on one single risk assessment document which can be adapted locally, if needed, but understood by all. The hope is that this initiative will encourage more working together.
	Maturing	A rehabilitation and reablement community of practice pan Sussex has been established which links with the major services review[70] and supports the 10-year plan.
East and West Kent	Maturing	There is a dedicated multi-organisation forum which is held every week for 20 mins. At this forum complex patients/service users are discussed. This is attended by a manager from social care, a manager from health and a representative from ICB commissioners, so they can agree on the equipment and special resources needed before submitting a request for the funding.

4.5.5 Strengthening the voice of Occupational Therapists in integration – the workshops

Repeatedly OTs observed that they felt under recognised. The Frailty Clinical Lead for NHS Kent and Medway ICB remarked that although senior medical staff recognise that **OTs are very important in enabling integration for the benefit of those who are frail. Nonetheless, exactly what they do is less clear**. This significant statement led to the ALIGNS team running two workshops about strengthening the voice of OTs in integration (each with the same agenda).

Workshop aim
The aim of the workshops was to identify activities, practical steps and outputs that can lead to strengthening the voice of OTs in integration across the South East.

Workshop objectives

Workshop attendees to

1. share their knowledge and expertise about their, and their wider stakeholders' perceptions of the roles of OTs in integration.
2. describe resources 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.

A total of 80 participants engaged in one or other of the workshops, primarily from the South East England OT workforce (social care and health).

The participants were asked to state what integration means to them and what is the one thing they could do, in their day-to-day work, to strengthen the voice of OTs in integration.

Using an anonymous poll the same three words/phrases predominated about what integration means to the participants: **Collaboration, Working Together, Seamless Pathways.** Between them the contributors suggested six activities that could be done as part of their day-to-day work to strengthen the voice of OTs in integration (figure 19). The feedback from the breakout groups was analysed. The resulting headline messages are included in (table 25).

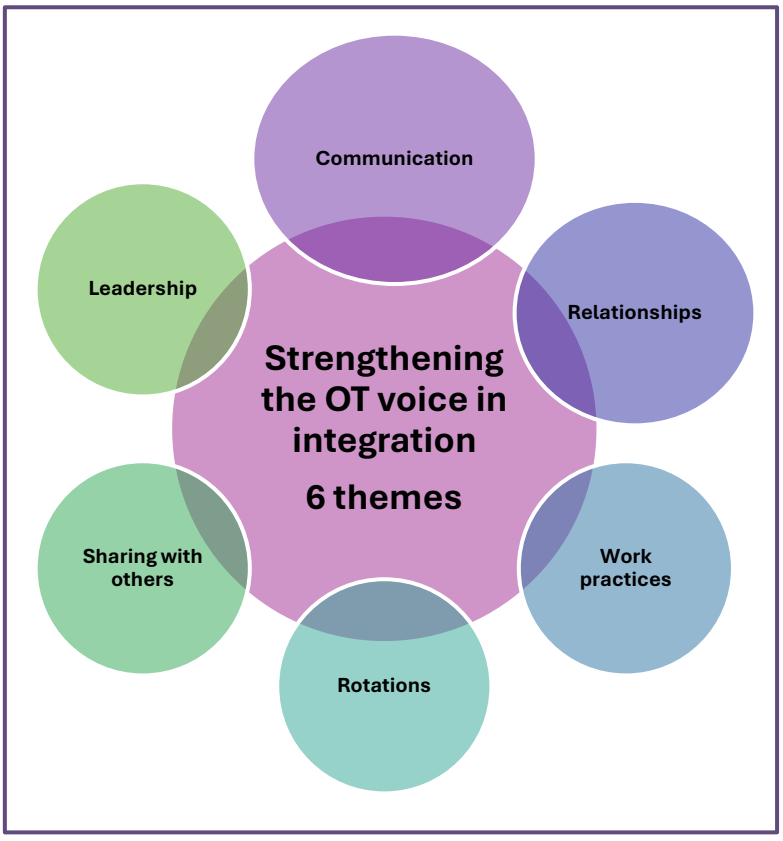


Figure 19: Proposed activities to strengthen the OT voice in integration

Table 25: Workshops' participants comments about integration

What integration means to staff	What can be done to strengthen integration	Headline messages from breakout groups
▪ Working together ▪ Collaboration ▪ Seamless (pathway)	1. Communicate effectively with colleagues in the other sector(s)/teams 2. Build relationships with colleagues in the other sector(s)/teams 3. Review work practices to strengthen integration 4. Facilitate student and staff rotations 5. Share information with those in different sector(s)/teams 6. Demonstrate effective leadership	▪ Integration isn't being discussed in acute settings ▪ Integration is only discussed by senior AHPs ▪ OTs need to be more confident about having conversations that strengthen their role in integration ▪ OTs are experts in activity analysis across the whole lifespan ▪ A key voice in integration is the patients' voice/voice of those with lived experience ▪ OTs are '*dual trained we have that superpower*' ▪ OTs understand the different models of care and are a good bridge between the sectors

For detailed information from each **Strengthening the OT voice in integration workshops** activity refer to annex 4.

5.0 General discussion, conclusions and recommendations

5.1 Introduction

This regionwide project has facilitated AHPs (primarily OTs) who work in social care and support those with lived experience, and their colleagues in health and the education sector, to come together as an ALIGNS Community. This has enabled colleagues to refresh partnerships, learn from each other and share examples of best practice.

Repeatedly the service users and their carers, who generously gave of their time, requested that the staff who supported their care only required the service user to explain their personal situation once. There are likely to be multiple times patients are asked for information rather than simply 'saying it once'. This needs to be considered in any future service development. People with lived experience could have a greater role in supporting and advising, from their experiences, early on and throughout the design, development, delivery and evaluation of the services provided by the teams.

> Recommendation 1
>
> Social care and health teams should review how often they require the service users to repeat information and proactively seek to reduce this burden, so the service users, their family members and carers only have to ***'say it once'.***

Before considering the main findings it is important to reflect on the limitations of this work that are relevant to the conclusions and recommendations. This study was conducted during a period when many of the Councils in the South East of England were undergoing a Care Quality Commission inspection (see annex 5). This had a significant impact on senior staff availability to engage in ALIGNS.

It is important not to conclude that findings that apply to one ICS e.g. H&IoW, apply to other ICSs. There is greater evidence from this ICS than from other systems. However, the recommendations apply to all Integrated Care Systems in the South East of England and will provide insight for the rest of the country.

Much of the data is qualitative and it is possible that such data may be skewed to present either the best or worst impression.

5.2 Overall level of maturity

To demonstrate the level of maturity the organisations were invited to complete a tool for dimensions 2-5. This required coordination at ICS level. It can be seen from the graphs (figure 20) below that some ICSs chose to provide detail by Local Authority. The self-reported data is either aggregated e.g. H&IoW or provided by local authority e.g. East Sussex.

H&IoW and Surrey Heartlands forwarded their self-assessment of the level of maturity for each dimension. The remaining ICSs worked with the ALIGNS team to populate the data collection tools (there was no data available for dimension 2 from Buckinghamshire).

Resources did not allow for reliability checks. Nonetheless, there is sufficient data to illustrate trends; show disparities across the region, and suggest major areas of improvement that could result in a better service for those with lived experience and their carers.

The overall map below of the level of maturity for AHPs leading integration, across the region, illustrates where the focus of activity should be.

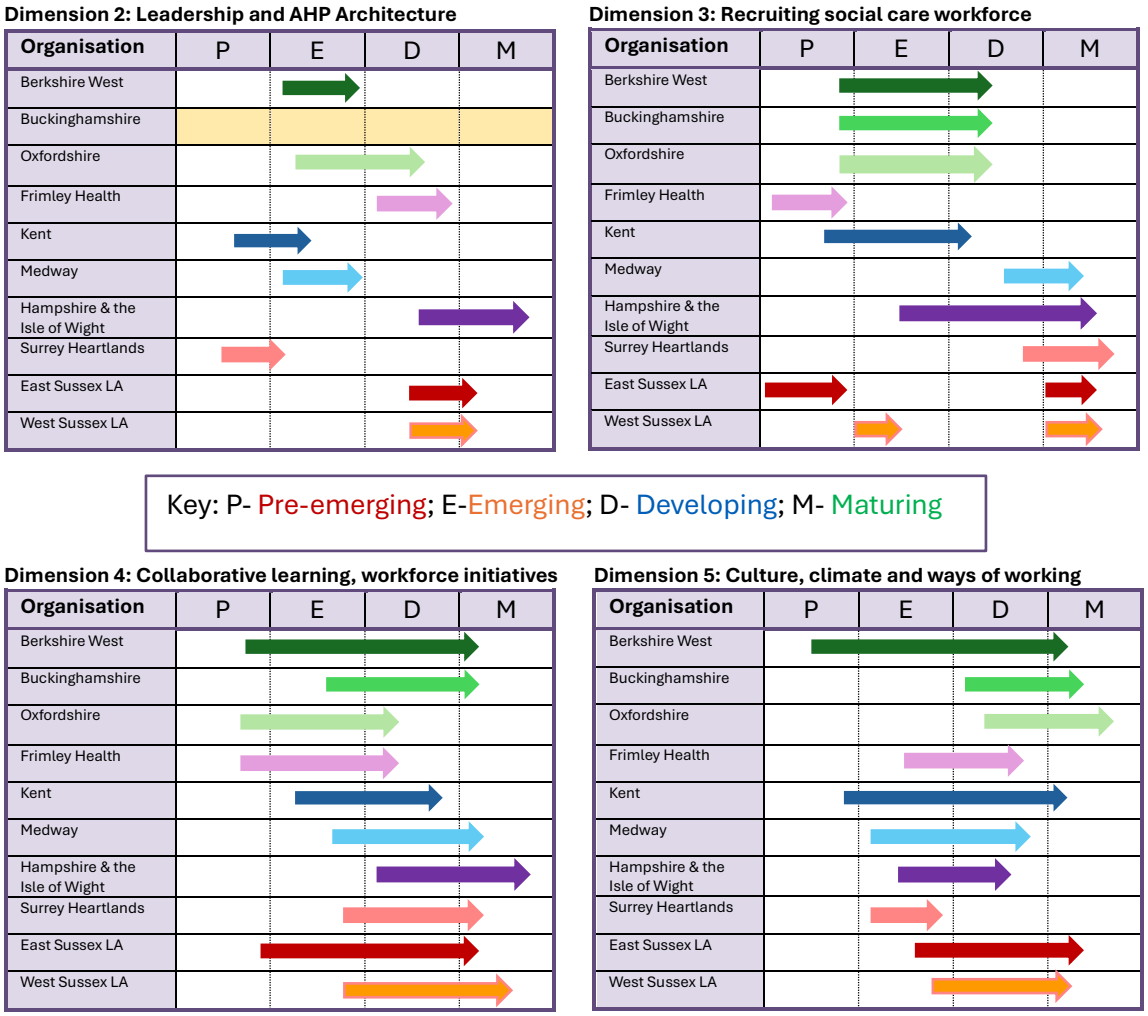


Figure 20: Self-reported level of maturity for dimensions 2-5

5.3 Occupational therapy employment and deployment - a key risk to integration

Occupational therapists are well placed to enable greater integration between social care and health, particularly community-based health services. The 2025 data, about where OTs are employed, revealed concerning risks to integration. The Skills for Care workforce data and the NHS workforce data fields are not aligned. There would be value in bringing these two data

sources together to facilitate a shared understanding of the occupational therapy workforce across health and social care. The pie charts in dimension 1 (figure 7, page 20) illustrate the challenge to integration, fifteen per cent or fewer of the ICS OT workforce are employed in NHS community services which is where people with complex needs require the expertise of this profession.

Recommendation 2

The ICS AHP leads in partnership with the Principal Occupational Therapists should review the model of occupational therapist employment, and deployment, and seek to refocus the services to facilitate integration.

5.4 Occupational therapy staffing structure

The senior staffing structure in social care across the region varies, with many OT social care teams reporting that there is no Principal Occupational Therapist or equivalent. Where this post exists, there was greater interest and engagement in the ALIGNS project. This was particularly evident where the ICS AHP lead, or nominated alternate, proactively engaged in the work: Buckinghamshire, Oxfordshire and Berkshire West; H&IoW, and Kent. This resulted in more data from these places and an opportunity to establish the case study sites (Buckinghamshire, Berkshire West and Kent and Medway). Repeatedly the respondents reported that the Care Act does not recognise the occupational therapy workforce and that the social workers have a more robust structure within ADASS (Association of Directors of Adult Social Care).

Recommendation 3

Principal Occupational Therapists in social care should be afforded the same opportunities as Principal Social Workers e.g. representation on regional committees and funding support for staff development, such as occupational therapists' preceptorship programmes.

5.5 Attracting occupational therapists into social care

The evidence from the ALIGNS project is that it is a lottery as to whether direct entry pre-registration students gain experience in social care e.g. availability of placements; access to placement site (driving licence); approach taken, by the education providers, to placement allocation. This is not the same for social care-based OT apprentices. The OT leads in social care are very positive about the apprenticeship programmes although they recognise that the pipeline for this model of delivery may not be sustainable.

There is considerable evidence: RePAIR[71] and the national preceptorship programmes, that students will seek employment in an organisation where they have had a positive placement experience.

Securing clinical placements for occupational therapy students is an ongoing challenge for the pre-registration programme coordinators in the South East. This is further exacerbated because

of the large number of new pre-registration OT providers, within and out with the region, which places extra demands on a highly competitive resource.

Additionally, the pre-registration OT placement model stipulates that the learners are placed in a particular service for many weeks. This does not allow for flexibility and increased access to limited social care placements.

Recommendation 4

NHSE South East Workforce Education and Training team are encouraged to establish an occupational therapy placement forum that includes all higher education occupational therapy course providers in the South East, and education leads for the health and social care partners. This forum should facilitate a fair and equitable placement allocation system that influences the pre-registration programme structure.

5.6 New ways of working and new roles

The ALIGNS case study sites provided a scenario to identity opportunities for closer working between social care and health (Kent and Medway), and also test the possibility of introducing new roles to support integration (Buckinghamshire).

Kent and Medway elected to gather information about the dissimilar approaches to Proportionate Care and Trusted Assessment taken by partner organisations across the ICS. The evidence highlights the importance of the stakeholders in Kent and Medway continuing to work together, and with colleagues across the region to further standardise the approach to proportionate care and trusted assessment. The teams collect very little data about the effectiveness of the approach they take.

Kent Community Hospital in partnership with Kent County Council developed a successful and popular new Home First Support Worker role to reduce the number of care packages required each day. This initiative required strong AHP leadership and was sponsored by the AHP Director of Integration.

The Buckinghamshire case study site, with the support of the Academy fully engaged in exploring new ways of working and new roles. This case study site developed three new role descriptors for volunteers to support occupational therapists, therapy support workers and the people who are transferred from the acute setting into community settings with assistance from social care teams. The sustainability of such an initiative was assessed. The relentless pressure on the system, as a result of the shortage of occupational therapists, and the increasing demands on the service, could be relieved by a strategic approach to engaging a trained volunteer workforce to assist the patients whose care is transferred from one sector to another.

The staff regularly noted that they, and their colleagues, are working to an enhanced level of practice, delivering an enhanced level of care. The Buckinghamshire case study site developed a proof of concept to test the feasibility of formally recognising an Enhanced Care Integration Team as an enabler to integration, underpinned by an ALIGNS education and career development framework. The principles were based on two successful care models and the very successful ACCEND programme. The concept principles were tested with three teams in Buckinghamshire to assess the extent to which form and function of these three teams aligned

to the principles. The concept of the ECIT approach, alongside the NHSE model of community rehabilitation and reablement model[72] should be seriously considered by social care and health teams. This will help to deliver streamlined proactive care, (aligned to Integrated Neighbourhood Health teams) by professionals who have the appropriate levels of skills, capabilities and confidence.

Recommendation 5

Social care and health teams, who support the same population, should review their models of care to ensure standardisation, optimisation and reciprocal recognition of the services.

Recommendation 6

Leaders of services (social care and health) should work together to reconsider the potential for utilising support workers.

Recommendation 7

Social care leaders, together with their partners in health, should explore the development of Enhanced Integrated Care Teams. They should identify which staff are working at an enhanced level within their scope of practice, and delivering an enhanced level of care. The team leaders should ensure these staff are given the opportunity to achieve enhanced level of practice, supported by the development of a national ALIGNS career, education and capability framework for staff across social care and health.

5.7 Strengthening the occupational therapy voice in integration

Throughout this project there has been expressed concern that OTs do not have the profile that would ensure they maximise their potential to support integration. The two ALIGNS workshops which focussed on this concern were very well attended. One of the key outcomes from the workshops was a request to facilitate an ongoing discussion, sharing of ideas and greater understanding about the different approaches to care across the region (social care and health). As noted under Dimension 5: culture, climate and ways of working together, building effective relationships is central to successful integration. However, across the South East these relationships are still developing, in part hindered by the incompatible IT systems. This project found little evidence about how interpersonal and organisational understanding is used to persuade and build collaboration between social care and health. Sussex has established an OT community of practice (social care and health) which is starting to address some of these issues.

Recommendation 8

The Principal Occupational Therapists and senior OT managers across social care and health, in the South East, should establish an Occupational Therapy Community of Practice. The focus should be to: a) strengthen the OT voice; b) develop an even greater understanding of the different approaches to care; c) learn from each other, and d) agree a model to support integration.

6.0 References

1. www.hee.nhs.uk/sites/default/files/AHPs%20Leading%20Integration%202022-2023.pdf (accessed September 2025)
2. https://www.legislation.gov.uk/ukpga/2014/23/contents (accessed August 2025)
3. https://www.socialworkengland.org.uk/about/data-and-research/data-and-insight/Demographics-diversity-of-register (accessed August 2025)
4. https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/Topics/Occupational-therapists.aspx (accessed August 2025)
5. Royal College of Occupational Therapists (2021) Principal occupational therapists in adult social care services in England: Roles and responsibilities (accessed November 2024)
6. https://www.rcot.co.uk/support-the-profession/workforce-strategy (accessed August 2025)
7. Cate Bennett; Jo Turnbull, Lynne Bowers 2024 Unlocking the Potential: Optimising Occupational Therapy as a High-Impact Resource chrome https://www.wm-adass.org.uk/media/mslnwgik/ahp-project-report-jun-24-final.pdf (accessed December 2024)
8. https://www.local.gov.uk/publications/occupational-therapists-councils-unlocking-capacity-and-driving-change (accessed August 2025)
9. Royal College of Occupational Therapists (2019) Relieving the pressure on social care the value of occupational therapy (accessed August 2025)
10. 2025 NHS Fit for the Future 10 Year Health Plan for England (accessed July 2025)
11. https://www.hee.nhs.uk/sites/default/files/AHP%20Leadership%20in%20Local%20Authorities.pdf (accessed September 2025)
12. https://www.hee.nhs.uk/sites/default/files/AHP%20Workforce%20in%20Social%20Care.pdf (accessed September 2025)
13. https://www.local.gov.uk/our-support/partners-care-and-health/adult-social-care-workforce/workforce-planning-hub/national (accessed October 2025)
14. https://www.gov.uk/government/publications/care-workforce-pathway-for-adult-social-care/enhanced-care-worker-role-category (accessed October 2025)
15. https://cahpr.org.uk/allied-health-professions-ahp-evidence-informed-policy-research-priorities-consensus/ (accessed October 2025)
16. https://www.hee.nhs.uk/our-work/primary-care/resources-updates/training-future-gp/population-health (accessed February 2025)
17. https://www.surreyheartlands.org/download.cfm?doc=docm93jijm4n1371.pdf&ver=1395 (accessed June 2025)
18. System Delivery plan 31 March 2022 (icb.nhs.uk) (accessed June 2025)
19. PowerPoint Presentation (fhft.nhs.uk) (accessed June 2025)
20. Hampshire_and_Isle_of_Wight_Joint_Forward_Plan_2023.pptx (live.com) (accessed February 2025)
21. Home - Kent Public Health Observatory (accessed February 2025)
22. Improving Lives Together Our ambition for a healthier future in Sussex (ics.nhs.uk)
23. Social Care Workforce: Skills for Care, Adult Social Care Workforce data (07/01/2025); NHS Workforce: ESR data warehouse (April 2025); Information taken from NHSE Workforce Information Portal, search criteria – NHS Community settings defined as WTE tertiary area of work – Other NHS services defined as WTE tertiary area of work all areas except community health services (accessed March 2025)
24. https://www.hee.nhs.uk/our-work/allied-health-professions/enable-workforce/developing-role-ahp-support-workers/ahp-support-worker-competency-education-career-development (accessed October 2025)
25. https://www.hantsiow.icb.nhs.uk/ahpfaculty/ahp-support-workers (accessed October 2025)
26. https://n-somerset.gov.uk/my-services/jobs-training/occupational-therapist-jobs/types-occupational-therapist-roles (accessed September 2025)
27. https://www.local.gov.uk/case-studies/making-case-principal-occupational-therapist-post-west-berkshire (accessed September 2025)
28. BMC Nursing 2024 **Situational leadership theory in nursing management: a scoping review** (accessed September 2025)
29. https://www.bgs.org.uk/sites/default/files/content/attachment/2024-05-15/BGS%20Reablement%20rehabilitation%20recovery%20-%20Everyones%20business.pdf (accessed September 2025)
30. https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf accessed September 2025)
31. https://www.gov.uk/government/publications/skilled-worker-visa-eligible-occupations/skilled-worker-visa-eligible-occupations-and-codes (accessed September 2025)
32. https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf (accessed September 2025)
33. https://www.hee.nhs.uk/sites/default/files/NHSE%20AHP%20Preceptroship%20standards%20and%20Framework.pdf (accessed September 2025)
34. https://www.hcpc-uk.org/resources/information/principles-for-preceptorship/ (accessed August 2025)
35. https://www.skillsforcare.org.uk/Regulated-professions/Social-work/ASYE/ASYE.aspx (accessed September 2025)
36. https://www.ahpf.org.uk/files/RCOT_%20Career%20Development%20Framework%20launched%20March%202021.pdf (accessed October 2025)
37. https://www.activeoxfordshire.org/ (accessed October 2025)
38. Optimising occupational therapy placements across social care (accessed October 2025)
39. https://www.kentcht.nhs.uk/service/home-first-2/
40. https://www.gov.uk/government/publications/hospital-discharge-service-action-cards/hospital-discharge-service-requirements-action-cards-for-staff (accessed October 2025)
41. Diane Lane and Sam Dawson (2023) A crisis in community care published in OT news (accessed February 2025)
42. https://sesca.org.uk/wp-content/uploads/2022/10/SESCA-Trusted-Assessor-Scheme-Review-Introduction-and-Summary.pdf (accessed October 2025)
43. https://www.england.nhs.uk/ahp/allied-health-professionals-job-planning-a-best-practice-guide/ (accessed October 2025)
44. https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf (accessed October 2025)

45. https://medway.bettercare.org.uk/ (accessed September 2025)
46. https://www.medway.gov.uk/directory_record/279313/ (accessed September 2025)
47. www.england.nhs.uk/wp-content/uploads/2016/03/ca1-enhncd-supprtv-care-guid.pdf - (accessed March 2025)
48. 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 (accessed March 2025)
49. White R, Stanley F, Than J et al. Treatable but not curable cancer in England: a retrospective cohort study using cancer registry data and linked data sets. **BMJ Open**. 2021;11(1):e040808. https://doi.org/10.1136/bmjopen-2020-040808 Crossref, Medline, Google Scholar (accessed March 2025)
50. https://www.england.nhs.uk/community-health-services/ehch/ (accessed March 2025
51. Creating Integrated Neighbourhood Teams: Learning from experience - National Association of Primary Care (accessed June 2025)
52. NHS England » Neighbourhood health guidelines 2025/26 (accessed June 2025)
53. Supporting Information: Care Transfer Hub (accessed June 2025)
54. A community rehabilitation and reablement model(accessed June 2025)
55. AHP enhanced practice | NHS England | Workforce, training and education (accessed June 2025)
56. Home - Skills for Care (accessed June 2025)
57. Aspirant Cancer Career and Education Development programme | NHS England | Workforce, training and education (accessed June 2025)
58. NHS England South East (2024) Community Workforce: Readiness to be upskilled to improve the health and wellbeing of the communities in which they work (available from NHSE W.T.&E.South East)
59. NHS England (2025) Aspirant Cancer Career and Education Development programme workforce survey. The_results_of_the_ACCEND_2025_NHS_cancer_workforce_in_England_survey.pdf
60. Enhanced care worker' role category - GOV.UK
61. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/NHS-Sustainability-Model-2010.pdf
62. https://thinklocalactpersonal.org.uk/news/introducing-the-the-new-language-hub-and-jargon-buster/ (accessed October 2025)
63. https://www.oxfordshire.gov.uk/residents/social-and-health-care/adult-social-care/oxfordshire-way (accessed October 2025)
64. https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance (accessed October 2025)
65. https://www.local.gov.uk/sites/default/files/documents/25.200%20Developing%20a%20Capacity_04_1.pdf (accessed October 2025)
66. https://www.iod.com/resources/governance/organisational-culture/(accessed October 2025)
67. https://www.cqc.org.uk/guidance-providers/adult-social-care/culturally-appropriate-care (accessed October 2025)
68. https://www.buckinghamshire.gov.uk/community-and-safety/partnerships-and-communities/opportunity-bucks/ (accessed October 2025)
69. https://www.oxfordshire.gov.uk/residents/social-and-health-care/public-health-and-wellbeing/oxfordshire-marmot-place/marmot-place-programme (accessed October 2025)
70. https://www.sussex.ics.nhs.uk/wp-content/uploads/sites/9/2025/07/3.2-Sussex-Strategic-Direction.pdf (accessed October 2025)
71. https://www.hee.nhs.uk/our-work/reducing-pre-registration-attrition-improving-retention (accessed October 2025)
72. A new community rehabilitation and reablement model (accessed October 2025

7.0 Appendices

7.1. Appendix 1: Membership of Project Oversight Group

Juliet Anderson, Director, Buckinghamshire Health and Social Care Academy

Aparna Belapurkar, Chief Allied Health Professional, CMO Directorate Kent and Medway ICB

June Davis, Director, Allied Health Solutions

Elizabeth Evans, AHP Workforce Programme Fellow, Buckinghamshire Health and Social Care Academy

Michaela Fell, Business Manager, Buckinghamshire Health and Social Care Academy

Dr Mark Gradwell, Head of AHP, Dental and Public Health, Canterbury Christchurch University

Professor Carolyn Llewellyn, Head of School: Sport Nutrition and Allied Health Professions (SNAHP), Oxford Brookes University

Professor Mary Lovegrove OBE, Director, Allied Health Solutions

Clare Mander, Chief Allied Health Professional, NHS Hampshire and Isle of Wight ICB

Maria Mitchell, Chair, Senior AHP workforce and education specialist: Integration, NHS England, W.T.&E. South East Region

Lauren Walker, Professional Advisor, Royal College of Occupational Therapists

7.2. Appendix 2: Organisations represented on the Expert Reference Group

Allied Health Solutions

Buckinghamshire Health and Social Care Academy

Buckinghamshire New University

Buckinghamshire Healthcare NHS Trust

Care City

Dartford and Gravesham NHS Trust

Devon County Council

Maidstone and Tunbridge Wells NHS Trust

National Care Forum

South East London Integrated Care System

7.3. Appendix 3: Dimension 2 Leadership and AHP architecture for social care - examples of activities

Example of activities within Dimension 2	Level of maturity			
	Pre-emerging Health and social care AHPs are working separately and areas for developing integrated ways of working are yet to be identified.	**Emerging** Health and social care AHPs are currently working relatively separately but starting to identify areas for developing integrated ways of working.	**Developing** Health and social care AHPs are working mostly in separation, but there are tangible shifts towards integrated working in particular facets of workforce development.	**Maturing** AHPs across health and social care are working seamlessly as 'one workforce' at place-based, system and regional level; working together to navigate workforce challenges and provide cohesive delivery of services.
Building relationships and rapport between regional PSLOT chair and NHS England SE AHP Leads*. *This statement is included for information as it is part of the implementation framework.				
Involvement with AHP Councils and Faculties.				
Ensure diversity and inclusion in representation in the PSLOT networks.				
Fully functioning and sustainable PSLOT network in the SE.				
All 46 Local Authorities and 12 Unitary Authorities in the South East have a named Principal OT.				
Ongoing collaboration with professional bodies e.g. RCOT.				
Senior leadership is critical for a strategic and sustainable approach to planning and delivering rehabilitation for older people. BGS 15th May 24 British Geriatric Society Reablement rehabilitation recovery – Everyone's business.pdf				
Robust links and relationships between regional networks, and wider AHP Councils and Faculties at system and regional level.				
Utilising the key principles of Clinical and Care Professional Leadership (CCPL) as an enabler				

towards diverse and integrated leadership[8].				
Situational leader* (s) in place through influence, with or without authority e.g. Enhanced practitioners. *Leaders who adapt style to each unique situation.				
To be able to use critically informed evidence-based approaches to advocate and lead operational and transformational change in complex situations and systems.				
Sustainable business support for the regional PSLOT networks and taskforce* *This statement is included for information as it is part of the implementation framework.				
All Principal OTs identify as an AHP Lead within their local authority.				
Clearly defined and direct links into: DHSC, ADASS, LGA and SfC via regional and national PSLOT network.				
PSLOT representation in all health and social care strategic decision-making and pathway development activity e.g. intermediate care and care workforce pathway.				
Strategic relationships exist to enable links across the broader care and health system.				
Please add here any other examples about effective leadership between Social Care and Health.				

[8] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf

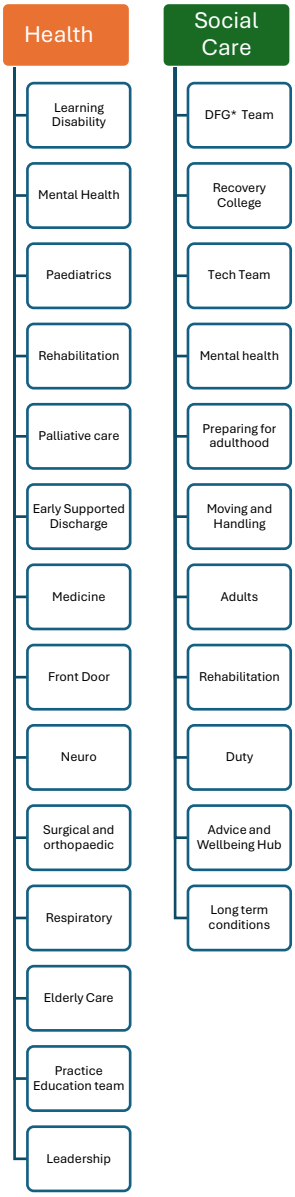
7.4. Appendix 4: Dimension 3 Attracting and recruiting the social care AHP workforce - examples of activities

Example of activities under Dimension 3	Level of maturity			
	Pre-emerging Health and social care AHPs are working separately and areas for developing integrated ways of working are yet to be identified.	**Emerging** Health and social care AHPs are currently working relatively separately but starting to identify areas for developing integrated ways of working.	**Developing** Health and social care AHPs are working mostly in separation, but there are tangible shifts towards integrated working in particular facets of workforce development.	**Maturing** AHPs across health and social care are working seamlessly as 'one workforce' at place-based, system and regional level; working together to navigate workforce challenges and provide cohesive delivery of services.
Agreed increase in OT student placements in Local Authority				
Agreed approach to apprenticeships				
OT students gain practice placement experience in Adult Social Care				
Local authorities working with Higher Education Institutions to recognise and promote the value of a social care career.				
Newly qualified OT rotation incorporating Social Care				
Robust preceptorship programme for staff new to LA employment				
Preceptor training in social care				
Legacy mentor post to support newly appointed staff				
Social care AHPs guest lecturing on local HEI courses				
Post-registration career development opportunities, with fluidity across health and social care as equal partners.				
Internationally educated OTs				
Staff new to role e.g., return to practice				
Please add here any other examples of how you have effectively attracted and recruited the AHP social care workforce				

7.5. Appendix 5: Number of occupational therapy apprenticeships 2018/19 – 2024/25

Academic Level 6	Academic year							
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 (Q1&Q2)	**Total**
Number	11	76	180	321	401	468	301	1758

7.6. Appendix 6: Examples of placement types for occupational therapy apprentices in Berkshire



7.7. Appendix 7: Dimension 4 Collaborative learning, development, state of workforce readiness and AHP workforce initiatives - examples of activities

Example of activities under Dimension 4	Level of maturity			
	Pre-emerging Health and social care AHPs are working separately and areas for developing integrated ways of working are yet to be identified.	**Emerging** Health and social care AHPs are currently working relatively separately but starting to identify areas for developing integrated ways of working.	**Developing** Health and social care AHPs are working mostly in separation, but there are tangible shifts towards integrated working in particular facets of workforce development.	**Maturing** AHPs across health and social care are working seamlessly as 'one workforce' at place-based, system and regional level; working together to navigate workforce challenges and provide cohesive delivery of services.
A mutual appreciation of all AHP roles across social care (local authorities) and health (NHS)				
A clear understanding of workforce learning and development requirements within both social care and health.				
State of AHP workforce readiness for future care Unique selling point – Extent to which members of the different allied health professions in social care have identified what they do that no one else can do				
Extending skills and knowledge to improve service efficiency and outcomes - Extent to which tasks/ roles that other professionals perform that could be undertaken by different AHPs in social care				
Enhancing the skills of others to improve outcomes – Identifying the skills and knowledge that different AHPs could develop in others				
Shared skills/knowledge – Identification of the generic skills and competencies that AHPs and other professions have which can enhance the experience of those with lived experience.				

Joint and equitable access and availability of all relevant learning and development opportunities across health and social care at **place-based system level.**				
Joint and equitable access and availability of all relevant learning and development opportunities across health and social care at **regional system level.*** *This statement is included for information as it is part of the implementation framework.				
Collaborative practice education and practice-based learning models across local authorities and NHS organisations, e.g., hybrid student placements.				
Shared continuing professional development (CPD) and training opportunities across **preceptorship.**				
Shared continuing professional development (CPD) and training opportunities across **enhanced practice.**				
Shared continuing professional development (CPD) and training opportunities across **advanced practice.**				
Integrated services and aligned workforce initiatives at **place level**				
Integrated services and aligned workforce initiatives **at ICS level**				
Integrated approaches to workforce and succession planning e.g. cross-organisational rotations, flexibility of workforce through use of **skills passports.**				
Enhanced practice programme working across health and social care settings.				
Developing **advanced practice** training opportunities; building a flexible skills-set across health and social care				
Mutually agreed consultant AHPs driving fundamental shifts in service delivery across health and social care.				
Digital working and solutions in adult social care The level of awareness of the What Good Looks Like (WGLL) framework for adult social care for digital working across social care and health. Digital working in adult social care: What Good Looks Like - GOV.UK (www.gov.uk)				

The What Good Looks Like (WGLL) framework for adult social care is part of a suite of guidance for digital working across health and social care, developed by NHS England and the Department of Health and Social Care (DHSC). It is structured around the following 7 success measures for digital working in adult social care services: 1. Well led 2. Ensure smart foundations 3. Safe practice 4. Support workforce 5. Empower people 6. Improve care 7. Healthy populations In health the application of the NHS digital framework for AHPs: 1. Digitally ready 2. Digitally mature this includes AHP services that are digitally mature can demonstrate effective integration and interoperability 3. Data enabled				
Please add here any other examples of the **beginnings of collaborative** thinking about shared workforce learning and development between social care and health.				
Please add here any other examples of **established effective collaborative shared** workforce development between social care and health.				

7.8. Appendix 8: Dimension 5 Culture, climate and ways of working together - examples of activities

Example of activities under Dimension 5	Level of maturity			
	Pre-emerging Health and social care AHPs are working separately and areas for developing integrated ways of working are yet to be identified.	**Emerging** Health and social care AHPs are currently working relatively separately but starting to identify areas for developing integrated ways of working.	**Developing** Health and social care AHPs are working mostly in separation, but there are tangible shifts towards integrated working in particular facets of workforce development.	**Maturing** AHPs across health and social care are working seamlessly as 'one workforce' at place-based, system and regional level; working together to navigate workforce challenges and provide cohesive delivery of services.
Recognition that there are language differences e.g., person with lived experience vs patient.				
Opportunities to use shared language have been identified.				
Understand how health and social care services fit together.				
Understand how different people, teams or organisations interconnect and interact.				
Understand the different operational processes used in social care and health organisations.				
AHPs understanding their role in their impact/effect on culture across social care and health.				
Recognise the implications of **different structures** for those who deliver and use the service.				
Recognise the implications of the **different goals** for those who deliver and use the service.				
Recognise the implications of the **different values** held by those who deliver the service.				
Cultural audits have been undertaken in both health and social care.				
Recognise the implications of the different cultures across social care and health.				
Clear understanding about which issues affect decisions across the system.				
Clear understanding about how complex connections across the				

health and social care economy affect the productivity and efficiency of the system.				
Clear understanding of the impact of how a rigid approach impacts on care.				
Relationships are being built to recognise other organisations' passions and concerns.				
Interpersonal and organisational understanding is used to persuade and build collaboration between Social Care and Health.				
Please add here any other examples of where there is a shared culture.				

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Enterprise Innovation Partnership