RCOT response to Policy Connect Call for Evidence: Improving Access to Primary Care Services, 27 February 2026.

Introduction

As the professional body for occupational therapists, we represent the profession across the UK including about 37,000 members. Our Workforce Strategy, published in 2024, aligns with the NHS 10 Year Health Plan.

Our vision is that by 2035, we will have an expanded occupational therapy workforce in primary care, positioned to have maximum impact in improving people's health and wellbeing. Occupational therapy will be embedded across systems and equipped to deliver care closer to home, drive prevention and early intervention, and embrace digital transformation.

Occupational therapists (OTs) play a vital role in supporting people's health and wellbeing across home, school, work, and community settings. Their work focuses on adapting environments, providing personalised care plans, and using digital tools and assistive technologies to improve independence and prevent health issues from escalating.

OT-led models in primary care are already delivering on the NHS's future vision by enhancing productivity, reducing pressure on acute services, and improving outcomes for diverse communities. These approaches ensure early access to support, and promote fair, needs based therapy-led services.

Successful primary care OT services combine universal, targeted, and specialist approaches to meet population needs efficiently, address inequalities, and support complex cases appropriately. OTs achieve the greatest impact when embedded in primary care teams, providing timely, personalised, prevention-focused care rooted in people's everyday environments.

However, current policy risks over-medicalising primary and neighbourhood health by emphasising medical roles and overlooking the enabling, relational and environmental expertise that OTs offer. Strong multi-professional collaboration and clear commissioning are essential for primary care, to avoid siloed working and role dilution.

Questions

3) What single policy change would most immediately improve patients' ability to be directed to the right primary care professional at their first point of contact, without the need for multiple appointments or repeated assessments and what evidence supports this?

The most immediate and impactful policy change would be mandating the inclusion of occupational therapists (OTs) and other AHPs within the core primary care workforce, supported by a dedicated and stable funding stream. While 90% of the public's contact with the NHS is via GP surgeries, 90% of the health workforce and funding is not there. This highlights the mismatch between demand and

workforce distribution. Ensuring OTs are commissioned as part of the first contact multidisciplinary team would allow patients to be directed to the right professional at the first appointment, reducing repeated assessments and unnecessary GP demand.

Evidence from a recent review (Coomber et al 2025) shows that realigning community OTs into GP surgeries improves early intervention, reduces escalation of need, and enhances patient flow. These models demonstrate that when OTs are embedded in primary care, they can provide rapid functional assessments, vocational advice, frailty prevention, and mental health support, reducing the need for multiple appointments.

6) What lessons or evidence can be drawn from local or regional models that have successfully improved access for underserved populations and what policy measures should be included in the 10-Year Health Plan to embed these approaches and reduce health inequalities?

Evidence demonstrates that OT led early intervention in primary care is effective for underserved groups (Coomber et al 2025). Particularly for falls and frailty prevention via home visits, vocational clinics to prevent worklessness, and mental health support. These models succeed because they are relational, prevention focused and embedded in the environments where people live and seek support.

To embed these approaches nationally, the 10-Year Health Plan should include:

(1) commissioning OTs as core members of primary care and neighbourhood teams,
(2) scaling universal–targeted–specialist (UTS) models to reach populations efficiently,
(3) protecting community based, non-medicalised roles that address the social determinants of health. OTs being based in primary care settings is critical, enabling timely, personalised care that reduces inequalities.

7a) What are the key structural or digital barriers that primary care providers face in achieving joined up working and system integration, and what policy changes, innovations, or practical solutions would best support seamless and collaborative primary care?

Primary care providers face significant barriers including fragmented digital systems, limited interoperability between health and social care, and inconsistent access to shared records. For example, 20% of the OT workforce is in local authorities who can't routinely or easily share information with healthcare colleagues in primary care, which undermines integrated care.

Many systems also fail to record the social determinants of health, limiting holistic assessment. Structural barriers include siloed commissioning, role dilution, and estate constraints that prevent co-location of multidisciplinary teams. Overcrowded GP estates and lack of consultation space hinder the integration of OTs and other AHPs into primary care teams.

7b) What national policy frameworks, funding mechanisms, accountability arrangements, or system-wide interventions are needed to address these barriers and ensure that digital transformation enhances rather than restricts equitable access to primary care services?

National policy should mandate interoperable digital records across health and social care, ensuring that functional needs, rehabilitation goals, and social determinants are routinely captured. Current systems compartmentalise people rather than being framed around person centred practice, which limits effective MDT working.

Funding mechanisms must support stable, long-term investment in multidisciplinary roles, avoiding short-term posts that destabilise services. Accountability frameworks should require ICSs to

demonstrate progress on integrated rehabilitation and early intervention, with clear expectations for AHP leadership and representation in system level planning.

13a) What are the main funding challenges affecting primary care service provision, including issues of allocation, timing, and stability. How do these challenges affect quality of service provision and workforce capacity?

Primary care faces challenges of insufficient allocation, short-term funding cycles, and lack of stability, which particularly affect AHP roles. Annual contract negotiations for primary care funding slows and destabilises progress. As the GP contract changes, funding for OT posts is being removed, leading to loss of staff and service regression. Misalignment between primary and community care budgets also creates tension and inhibits whole system planning.

These challenges reduce service quality by limiting early intervention capacity, increasing waiting times, and undermining workforce retention. Instability discourages innovation and prevents the embedding of prevention focused roles that reduce long-term demand.

13b) What opportunities exist to use current resources more efficiently across the primary care sectors and what are the likely impacts of such changes? Please include case studies using the template provided and outline any system-level adjustments required.

Efficiency gains can be achieved by shifting workforce capacity upstream, ensuring OTs and other AHPs deliver prevention, rehabilitation, and self-management support rather than low value tasks. Staff may be providing low value input in secondary care, but could offer much higher value, preventative work in primary care. Using the UTS model allows universal digital interventions to free capacity for targeted and specialist care.

Case study summaries (see table at end)
• Impact of OT for older adults, Rocket Science: early OT home visits reduce falls risk and prevent escalation.
• Wakefield vocational clinics: keeping people in work reduces health service use.
• First contact mental health OT in GP surgeries: improves access for groups who avoid GP surgeries.

System level adjustments include shared funding across primary and community care and clearer measurement of value to guide resource allocation.

13c) What changes to GP funding models are needed to improve patient access to primary care, and how can additional investment be targeted, structured, and monitored to ensure it delivers measurable improvements in access, capacity, and outcomes for patients?

GP funding models should explicitly include ringfenced funding for AHP roles, enabling OTs to be commissioned as core members of the primary care MDT. The current contract negotiation excludes AHPs, so we are not given the chance to influence the form or function of our own services. Funding should follow function, supporting prevention, rehabilitation, and early intervention.

Additional investment should be tied to measurable improvements in access, capacity, and outcomes, including reduced GP appointments, improved functional independence, and reduced acute demand. Oversight through ICS level AHP leadership would ensure governance and sustainability.

13d) Aside from funding, what system-wide reforms or policy levers would have the greatest impact

on improving access to primary care and which should be prioritised?

Key reforms include: (1) embedding OTs in neighbourhood teams, (2) strengthening AHP leadership within ICSs, and (3) mandating integrated digital records. Integration is hindered when primary, community and social care are not at the forefront of consideration and planning. Ensuring rehabilitation leadership in every ICS would support consistent access to early intervention. Reducing over-medicalisation of community care and protecting enabling, relational roles would also improve access by addressing the root causes of poor health and functional decline.

17a) How can the primary care estate be developed or used to improve access to care, particularly as services shift toward a neighbourhood model with an increased emphasis on community-based delivery?

Primary care estates must expand to support multidisciplinary teams, including dedicated space for OTs. GP practices are often overcrowded, limiting the ability to integrate new roles. Investment should prioritise consultation rooms, group therapy spaces, and community wellbeing hubs that support prevention and rehabilitation.

Colocation is valuable but not always essential; what matters is clear models of care and optimised communication. Estates planning should follow service function, ensuring environments support early intervention and community-based delivery.

19a) What evidence-based staffing models or multidisciplinary workforce compositions best enhance primary care capacity, improve outcomes, and reduce pressure on GPs?

The most effective models use multidisciplinary teams with OTs embedded across universal, targeted, and specialist tiers. This approach enables scalable prevention while ensuring specialist input for complex needs. OTs deliver holistic assessment, personalised care planning, and environmental adaptation, which reduce pressure on GPs and improve outcomes.

Case studies show that OT led models in frailty, vocational rehabilitation, and self-management reduce acute demand and improve access for underserved groups. Embedding OTs in GP practices, schools, and community hubs enhances capacity and system productivity.

19b) What role should accelerated training pathways and expanded scopes of practice (e.g. prescribing pharmacists, advanced nurse practitioners, dental therapists, independent prescribing optometrists) play in strengthening GP primary care?

Accelerated pathways and expanded scopes, such as prescribing rights for advanced OTs, would strengthen primary care by enabling practitioners to manage a broader range of needs without GP input. Consultant OTs can't yet prescribe medicine that would improve people's ability to do their everyday activities, despite their expertise.

Expanded scopes should be accompanied by robust governance, supervision, and career pathways, ensuring safe practice and supporting retention.

21a) Which policies, practices, or initiatives have been most effective in recruiting, retaining, and supporting the primary care workforce across GP, dentistry, pharmacy, and optometry?

Effective approaches include stable funding, clear career pathways, strong clinical leadership, and exposure to primary care during training. Short-term primary care funding reduces staff wellbeing and undermines retention. Areas that have successfully recruited OTs into primary care have provided supervision, CPD time, and alignment with NHS pay, terms and conditions.

25) What role should local authorities play in neighbourhood health systems and preventive public health within primary care?

Local authorities should play a central role in prevention, early intervention, and addressing the social determinants of health, working alongside primary care. Many OTs in local authorities cannot share records with health colleagues, despite their critical role in housing, employment, and community support. Strengthening integration would enable more holistic care.

Local authorities should co-lead neighbourhood models, ensuring that housing, education, employment, and community assets are embedded in health planning. Their involvement is essential to reducing inequalities and delivering person-centred, place-based care.

Case studies

Below is a snapshot of examples and evidence demonstrating impact of occupational therapists in primary care. For further information about them, please contact Genevieve.Smyth@rcot.co.uk.

Title and context	Intervention and outcomes	Enablers and benefits
North Sedgemoor Primary Care Network **WEllbeing Works - North Sedgemoor Group Clinics 2025** Delivered by an alliance of partners in the local community working in an integrated, local way.	A primary care occupational therapist co-designed and delivered a group clinic model for people with heart failure, working alongside GPs, nurses, and community partners. The clinics support people to manage their condition through lifestyle changes, environmental adaptations, and peer-led support. The OT used coaching and enablement approaches to help individuals build confidence, reduce reliance on acute services, and improve quality of life. **Impact-** • High-volume, lower-cost intervention: clinicians can see 30 people a day instead of 5 – 8 per day • Improved patient outcomes and experience • Increased workforce capacity and released staff time • Strengthened community ownership and engagement	**Use of digital tools**: AI risk stratification helps identify those most likely to benefit, ensuring efficient targeting of resources. **Flexible workforce deployment**: Partners agreed locally on how to use the workforce across the system, enabling more responsive and integrated care. **Benefit of peer support:** group clinics foster a sense of community, enabling patients to connect with one another and with staff. This personal, relational approach helps humanise the NHS and strengthens engagement. **Closer integration with community assets:** The model enables OTs to work alongside social prescribers, voluntary sector partners, and local community groups – creating a joined-up, holistic approach to care that reflects what matters to people.
OT-led Vocational Rehabilitation Service in Primary Care	The largest OT-led vocational rehabilitation service in primary cared England, supporting	**Proximity to people and services**: Being embedded in primary care settings allows occupational therapists

Wakefield	individuals at risk of leaving work due to health conditions. OTs assess work related functional capacity, coach individuals to manage health conditions in the workplace, and liaise with employers and GPs to support return to work plans. **Impact**: Contributed to a reduction of 1,700 people off work in the Wakefield area and achieved a 40% reduction in Med-3 fit notes within pilot GP practices. 94% of patients on long-term sick leave in one Primary Care Network successfully returned to work, demonstrating the effectiveness of early intervention in primary care. 85% of patients showed improvements on the Workability Support Scale, showing increased ability to work	to support individuals where they are most likely to seek help—close to home and at the point of need. This enables timely intervention and builds trust with patients. **Collaborative working with GPs and the wider MDT**: Co-location with GPs and other health professionals facilitates joint working, shared decision-making, and smoother referral pathways. It also enhances understanding of the OT role among colleagues, which is critical for effective integration and sustained impact. **Recognition of OT's unique contribution**: Success is supported by a clear understanding among primary care teams of the distinct value occupational therapists bring—particularly in assessing functional capacity, coaching for workplace health, and enabling return-to-work plans. **Cross-PCN collaboration**: The service benefits from coordinated working across four Primary Care Networks, allowing for consistent delivery, shared learning, and broader population reach.
Early intervention approach for mental health in Nottingham West PCN.	First contact mental health OTs in GP surgeries are identifying and addressing mental health needs early on. Group work enables them to see multiple patients. They offer a rolling group programme accessible to all individuals registered within a GP surgery in Nottingham West PCN. For example, the mental health skills group focuses on anxiety and depression management, goal setting, compassion, mindfulness and motivation for change.	**Accessible services:** People can access support from mental health OTs without a referral from a GP. **Timesaving and cost effective:** Saves GP time and associated financial costs. **Prevention and early intervention:** Improved outcomes for people and populations. **Reducing pressure:** By intervening in a more focused way, the OTs provide preventative work and reduce pressure on already overburdened services.
OTs using AI in primary care, North Sedgemoor PCN	Occupational therapists in primary care used the Brave AI tool to identify older adults in care homes at risk of hospital admission. This	**Access to Data**: Brave AI analyses GP data to predict with 97% accuracy a person's risk of hospital admission, enabling proactive intervention and

	allowed for proactive, preventative interventions. **Impact** • Care home pilot- reduced falls by 35% • Reduced attendance to A&E by 65% • Reduced ambulance calls by 8.7% • Reduced future costs on services	transforming healthcare from reactive to preventative approaches. **Removing traditional referral systems:** This AI tool liberates occupational therapists from traditional referral systems, allowing them to find and support people who might otherwise be missed, resulting in significant reductions in hospital admissions, falls, and ambulance call-outs. **Leadership:** The system elevates occupational therapists as leaders in integrated healthcare teams, shifting focus from medical models to social and public health approaches that consider what matters most to the person. **Measuring outcomes:** While powerful stories demonstrate human impact, collecting data is essential for scaling innovations, securing funding, and expanding successful approaches across healthcare systems.
Impact of OT for Older Adults in primary care, Rocket Science.	Mixed methods study across England, Scotland, Wales and 17 primary care practices with OTs delivering interventions for older adults. **Impact** 77% of patients showed improvements in their health through the EQ-5D-5L from initial assessment to point of discharge. Many said that if occupational therapy hadn't been available, they would have had to by seen the GP.	**Primary care staff valued OT skill-mix.** Staff felt that the occupational therapists were providing timely access for patients without the need for a GP appointment. They consistently said that if the role was not available, it would result in longer waiting times, poorer patient experiences and outcomes. **Job satisfaction:** The occupational therapists had high levels of job satisfaction as they could provide early interventions and holistic care.

The value of the occupational therapy workforce in primary care: A rapid review - Caroline Coomber, Genevieve Smyth, Elizabeth Taylor, 2025	Review of evidence for OT in primary care. 16 papers included. OT interventions included falls prevention, frailty services, lifestyle management programmes, medication adherence, mindfulness and vocational clinics. **Impact:** The evidence supported the positioning of the occupational therapy workforce in primary care particularly in the areas of falls interventions, frailty services and self-management support programmes.	**Co-Location:** Where occupational therapists were co-located with primary care professionals, this fostered communication, information sharing and a better understanding of occupational therapy.