CENTRE FOR WORKFORCE INTELLIGENCE

MAKING THE MOST OF **ALLIED HEALTH PROFESSIONALS**

WORKFORCE PLANNING FOR QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION

A thought leadership paper

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CONTENTS

CONTENTS

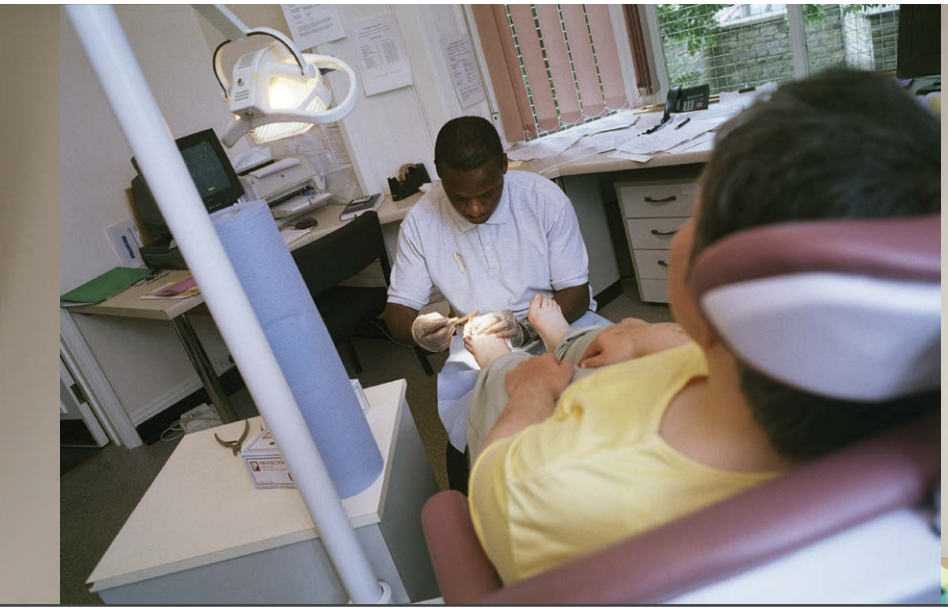
Why the AHP workforce matters: the perspectives of experts by experience

As someone with an array of long-term conditions, I have personally experienced and benefited from the knowledge and expertise of many caring allied health professionals, including prosthetists, orthotists, physiotherapists, occupational therapists, radiographers and dietitians. Whilst these individual professionals seem distinctly different in the skills they possess and the services they provide, they share many common goals, including trying to keep people mobile, independent, dexterous and out of hospital. So as someone who continues to benefit from the mobility and independence afforded to me, I feel it can only be to the benefit of all that these opportunities are shared and made as widely accessible as possible.

Steve McNeice
Expert by experience

While I have had only passing experience of the valuable work of AHPs in a relatively healthy life, I have unfortunately had to experience and appreciate the input of these healthcare professionals during the lengthy treatment and care, and eventual death of my youngest son through Hodgkin's Lymphoma. His varied treatments through chemotherapy, stem cell transplant and radiotherapy had been radical, uncomfortable and at times very painful. But his courage and spirit were helped, especially in the later months, by the involvement of very caring nursing staff and the skill and personal attention and encouragement of the physiotherapist and dietitian. With their knowledge, gentle coaxing and genuine friendly warmth and concern, they were able to enhance the quality of his remaining days and lift the spirit of both my son and those of us who loved him. I have the feeling that, through their generosity of time, kindness and skill they also received much in return and shared in the sadness of his passing. I will remember them.

Bill Davidson
Carer



1 Allied health professionals as optimisers of healthcare and support

Allied health professionals (AHPs) are a diverse group of professionals who deliver high-quality care across a wide range of health and social care pathways and in a variety of different settings – from people's own homes to hospitals.

The roles that come under the banner of allied health professions are: art therapists, dramatherapists, music therapists, chiropodists/ podiatrists, dietitians, occupational therapists, orthoptists, prosthetists and orthotists, paramedics, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists.

The Centre for Workforce Intelligence (CfWI) convened an AHP thought leadership group to engage a community of individuals with a shared interest in workforce issues in the provision of AHP services. As a key output of the group, this report aims to complement the AHP Quality Innovation Productivity and Prevention (QIPP) Toolkit, produced by NHS London on behalf of the Strategic Allied Health Professionals Leads Group (NHS London, 2012). The QIPP toolkit demonstrates how AHP interventions can reduce costs and improve outcomes for people along each major stage of various pathways.

This paper provides high-level thought leadership to support those responsible for commissioning services and education, including local education and training boards, by giving an overview of the latest thinking around AHP interventions across care pathways, the benefits they can provide to people using AHP services and their carers, and the workforce implications of establishing AHP QIPP pathways.

According to the Health and Social Care Information Centre, there were 73,851 full-time equivalent* AHPs working in the NHS in England as at September 2011 (Health and Social Care Information Centre, 2011). Significant and increasing numbers of AHPs work in other public services, including social care and education, as well as in the private, independent and third sectors (Department of Health, 2011). AHPs have a number of common attributes, and:

- are, in the main, first-contact practitioners
- work across a wide range of locations and sectors in acute, primary and community care
- perform functions of assessment, diagnosis, treatment and discharge throughout care pathways across health and social care.

These attributes are essential for transforming and sustaining high-quality integrated services in the future.

The knowledge, skills and experience the AHP workforce bring are crucial in providing sustainable services that not only add years to life, but also add life to years (Department of Health, 2011).

Making the most of AHPs builds on the QIPP toolkits and provides thought leadership on workforce issues. This paper draws on published evidence, local studies and good practice, alongside a series of round-table discussions, to consider factors such as educational changes, the effective use of skill mix and the use of advanced and extended scope of practice roles. The leadership issues described in this report are not exhaustive. Our intention is to start the debate and consider some of the workforce challenges and opportunities involved in delivering the QIPP transformation agenda.

Over 73,000 AHPs work in the NHS in England

* This includes approximately 10,914 ambulance paramedics.

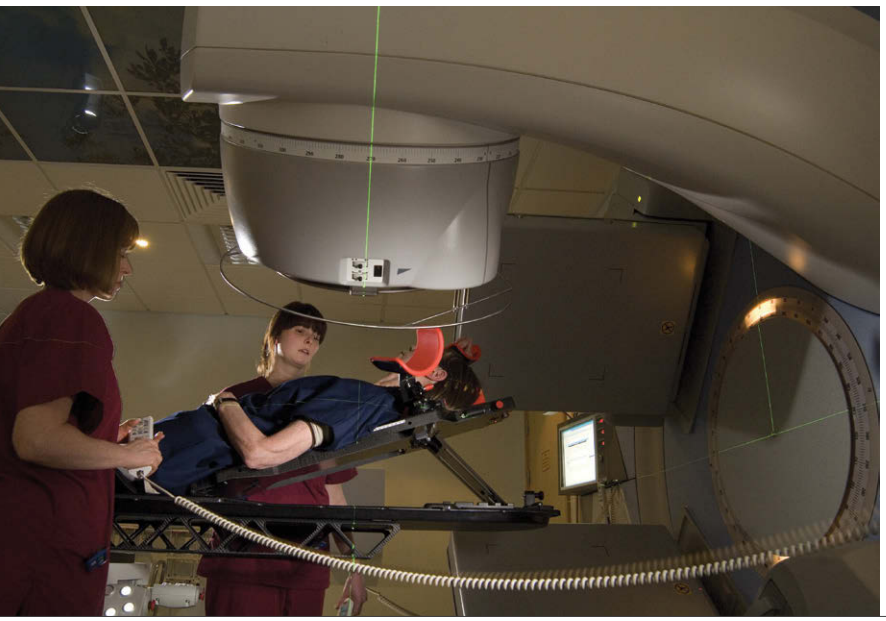
2 Quality, innovation, productivity and prevention (QIPP): the workforce implications for the allied health professions

QIPP is a large-scale transformation agenda for the NHS workforce and its partners. To support the QIPP agenda for AHPs, NHS London (2012) working with the Strategic Allied Health Professionals Group, produced a series of toolkits, *How AHPs improve patient care and save the NHS money*. The toolkits were prepared on behalf of the Strategic Allied Health Professionals Leads and partially funded by the national AHP Professional Advisory Board.

How AHPs improve patient care and save the NHS money. Find out more at: www.networks.nhs.uk/nhs-networks/ahp-networks/ahp-qipp-toolkits

The AHP QIPP toolkits are an online, interactive resource demonstrating how better use of AHPs improves care and outcomes for people while making better use of finite resources. The toolkits are targeted at commissioners and clinicians and clearly illustrate how AHPs add specific value along care pathways, demonstrating at each stage how AHP interventions improve outcomes while making better use of resources.

Improvements to care and reductions in costs through the use of AHPs can be identified along each care pathway. The five care pathways examined in the QIPP toolkits are: cancer, diabetes, musculoskeletal disorders, oral nutritional support and stroke.



3 Making the most of support workers and assistant practitioners

Support workers and assistant practitioners have a key role to play in healthcare (Skills for Health, 2011a), and can support improved skill mix for AHPs (Lizarondo et al., 2010). They can take on tasks that would otherwise be delivered by registered staff, freeing staff to deliver what they have been trained for. Using support workers and assistant practitioners as part of the skill mix of a team can therefore further enable the development of advanced practitioners and consultant AHP roles.

Support workers and assistant practitioners work alongside AHPs in specific roles such as physiotherapy support work, or across pathways such as in diabetes care. However, much more could be made of both uni-professional and multi-professional support workers and assistant practitioners.

Historically there has been limited research on the impact of AHP staffing levels on clinical outcomes (Cartmill et al., 2012) and, more generally, not enough is known about how best to use support workers and the impact of changes in skill mix and roles (SDO Network & NHS Confederation, 2011).

However, the emerging evidence suggests that such roles can improve clinical and service outcomes (Griffin and Sines, 2012). For example, Skills for Health (2011b) describes how the introduction of two clinical therapy assistant roles led to reduced lengths of stay for older people and people who have had a stroke at the Whittington Hospital NHS Trust.

Making the most of assistant practitioners working in orthopaedic therapy

Band 4 therapy technicians in the orthopaedic therapy team at Southampton General Hospital have taken a lead role in pre-operative education classes since the introduction of the enhanced recovery programme (ERP) for elective total hip replacements and knee replacements in 2011.

Due to their dual training in occupational therapy and physiotherapy, support workers are well placed to answer queries. The education classes provide information and advice on surgery and rehabilitation. This is an invaluable service, which has received positive feedback as it prepares people for their surgery and empowers them to be actively engaged in their recovery. Since the introduction of the ERP, the length of stay has decreased and user satisfaction increased.

4 Making the most of pre-registration education

Entry into the allied health professions is predominantly at BSc (Hons) level with the exception of paramedics, who may take a diploma or foundation degree, and the arts therapies, where entry to the profession requires a masters qualification. The length of pre-registration programmes varies, but is usually three or four years as an undergraduate and two years as a postgraduate student. Some postgraduate programmes have been introduced that enable graduates with a relevant first degree to undertake a shorter pre-registration programme at postgraduate level.

With the wholesale changes in health service organisation, including the establishment of Health Education England and local education and training boards, there is a risk that practice placements for AHPs may become less available. This is especially true with the advent of the any qualified provider policy, with no incentive for new providers to offer such placements. This is already evident in the provision of musculo-skeletal placements for physiotherapists and community placements for speech and language therapists. The allocation of some funding to follow all non-medical healthcare students on placement is welcomed, though this has been set at a low level and may not necessarily cover the costs of providing these placements. Obtaining an adequate quantity of high-quality practice placements is critical to the development of AHP roles, both today and in the future. It is important to ensure placements continue to be offered to students, despite the present economic climate. Incentivising placements could help to embed the importance of high-quality placements.

Practice educator training is not mandatory in allied health, but some of the AHP professional bodies, including the College of Occupational Therapists, Society and College of Radiographers, Chartered Society of Physiotherapists and Society of Chiropodists and Podiatrists, provide nationally accredited programmes (Department of Health and Skills for Health, 2008). It is important to recognise the significance of practice educators in maintaining and improving the quality of placements, as service delivery models change and respond to personalisation and the extension of choice.

Making the most of AHPs by using 'role-emerging placements' in occupational therapy

'Role-emerging placements' have been championed by the College of Occupational Therapists. This has led to innovation in practice placements for occupational therapy students. In particular, private and voluntary organisations, where there is not an established occupational therapy role, take students to explore the potential for occupational therapy with long-arm supervision, either from the university or an occupational therapist in another organisation (Department of Health, 2011).

5 Making the most of AHPs as clinical academics

The academic workforce is critical to ensuring the future supply of AHPs. The first report from the NHS Future Forum on education and training stated that 'healthcare education and training must deliver excellence in practice' (DH, 2012a). The subsequent development of the draft education outcomes framework highlighted the need for high-level strategic workforce planning, education and training alongside professional development, research and innovation (DH, 2012b). The success of these new developments for services delivered by AHPs is dependent on an academic workforce that is fit for purpose.

It is important to maintain a focus on the contribution the AHP academic workforce can make to care through teaching and research. In particular, when workforce planning, it is important to take into account the sustainability of the academic workforce. Smaller professions, where reductions in education commissions could lead to programmes becoming untenable, could result in a loss of academics from the system. The priority for improving outcomes for people is to secure high-quality education, training and research by maintaining and sustaining a high-quality research-skilled academic workforce.

The current trends towards reduced education commissions for most AHPs could mean that any future shortfall in academic staffing may not be quickly recovered if education commissions increase. As services are redesigned and clinical lead posts are removed, it may become increasingly difficult for AHPs to develop academic and research careers. The National Clinical Academic Training Pathways are beneficial in supporting the work being done locally to develop clinical academics (www.nihrtcc.nhs.uk). Further improvements include joint posts between universities and services to further promote the translation of academic research into practice, alongside role modelling for AHPs wanting to develop their academic careers. In turn, these posts should also improve the quality of education provided.

The National Institute for Health Research (NIHR) offers a number of different research training programmes for AHPs who aspire to develop their academic career. The most notable is the Clinical Academic Training Programme, which operates at four levels: Masters in Clinical Research; Clinical Doctoral Research Fellowship; Clinical Lectureship and Senior Clinical Lectureship. AHPs have performed well in securing these prestigious awards, particularly at the Clinical Doctoral Research Fellowship level.

The current economic climate may lead higher education institutions to rethink learning opportunities, with more teaching and learning being offered online. It is important to avoid a situation of 'dry land' education where students seldom get the opportunity to learn in a real clinical setting.

Making the most of AHPs with joint appointments

Joint lecturer practitioner posts can work well to ensure integration between practice and education. In the School of Rehabilitation Sciences, Faculty of Health, Social Care and Education, a partnership between Kingston University and St George's, University of London, a Band 7 physiotherapist works in acute respiratory care as a lecturer on the pre-registration BSc and MSc physiotherapy programmes run by the school. This ensures practice and education are informed by each other and increasingly work together to ensure the best practitioners are educated. Both clinical and academic staff are seeing the benefit of this approach.

6 Making the most of preceptorship

Preceptorship is a structured transition phase allowing newly qualified AHPs to develop their confidence and apply knowledge, skills and competences acquired as students to their area of practice, laying a solid foundation for life long learning. Preceptorship should be seen as a model of enhancement, which acknowledges new graduates and registrants as safe, competent but novice practitioners who will continue to develop as part of their career development and continuing professional development (Department of Health, 2010a).

A number of the allied health professions, notably occupational therapy and orthoptics, have well-established models of preceptorship delivered through professional bodies (Department of Health, 2011). Preceptorships in allied health can be valuable in embedding leadership development and research into the AHP culture, as well as ensuring that the system has the confident practitioners it needs to work in new and emerging models of care delivery.

Access to preceptorship is not uniform across the professions, particularly where employment models are predominantly outside the NHS, for example prosthetists and orthotists. A potential solution could be for preceptorship to be included in future commissioning arrangements.

Making the most of occupational therapists through preceptorships

The London mental health professional lead occupational therapy group, on behalf of the College of Occupational Therapists, devised a preceptorship programme to support new practitioners as they start work. The programme supports career progression to advance clinical reasoning. This increases clinicians' confidence and competence to deliver better outcomes and experiences for people using services (College of Occupational Therapists, 2012).

7 Making the most of advanced practitioners

Making better use of advanced practitioners and consultants is a potentially key element of meeting the QIPP agenda by:

- improving the quality of services by advancing practice
- leading innovation through research and development
- improving productivity by leading service redesign
- leading prevention and preventing both admissions and readmissions.

Advanced practice roles enhance the prospect for career progression and attract more high-quality applicants to the professions. Where no advanced practice roles exist, it is more difficult to recruit and retain high-quality staff (Department of Health, 2010b). Advanced practice roles can form part of the 'psychological contract' that motivates employees and creates higher job satisfaction and the willingness of staff to contribute over and above their 'core contract'. In turn, AHPs can develop the competences associated with advanced practice roles.

Advanced practitioners will have competences that overlap with other professions and grades, and this provides opportunities for substitution: that is, an advanced practitioner carrying out a task which would otherwise be carried out by another clinician. These tend to allow for the optimum use of existing resources.

Making the most of AHPs by diagnosing fractures

NHS Employers (2011) describes how South Tyneside NHS Foundation Trust has demonstrated the benefits and positive outcomes on service delivery through advanced practice. The trust implemented a strategy where all its radiographers carry out initial reporting; and failure to diagnose fractures in the trust decreased steadily from 7.3 per cent in 2002 to 0.7 per cent in 2010, thereby improving outcomes for people and reducing accident and emergency waiting times. This approach encourages multidisciplinary working and provides staff with enhanced career development.

Making the most of AHPs working with people affected by musculoskeletal disorders

The musculoskeletal disorders toolkit shows how extended scope practitioner role development can improve outcomes and save money. Extended scope occupational therapy (hand therapy) services has been developed at Guy's and St Thomas' Hospital and includes diagnosis assessment and planning treatment up to surgery if required. People can be seen after two weeks rather than waiting 12 weeks for a consultant appointment (NHS London, 2012).

8 Making the most of AHPs as clinical leaders

Strong clinical leadership across all of the AHPs can be used to drive improvements in service delivery and enhance the quality of care for people using services. Effective clinical leadership is one of the key enablers to harness the potential of the AHP workforce, as leadership is required to drive collaboration, research, evidence-based diagnosis, treatment and care.

The AHP career framework takes a competence-based approach to service delivery, meaning that the right person with the right skills provides the right care (Department of Health 2008). AHPs' clinical skills can be developed and transferred into leadership roles. By taking a competence-based approach to leadership, AHPs will have more transparent opportunities to move into leadership roles, thereby removing some of the current barriers from the system and releasing diverse leadership talent. This will maximise creativity and drive up both quality and productivity, while also increasing the visibility of AHPs, especially among the smaller professions.

The development of clinical commissioning groups and clinical networks and senates provides opportunities for AHPs to use their leadership skills to demonstrate the contribution of the whole AHP workforce across care pathways (Keogh and Dalton, 2012). However, for this to be effective there needs to be a strong AHP voice, rather than uni-professional representation. Inter-professional learning and education, from pre-registration level onwards, will support this alongside effective clinical leadership.

Service redesign should include effective clinical and professional leadership at an appropriate level to ensure services have the right skill mix. Clinical leaders, supported through multi-professional development opportunities, can move away from traditional programmes of delivery to include action learning, mentoring and coaching. In addition to this, talent management systems should support succession planning strategies for emerging clinical leaders to be developed.

Making the most of AHPs working in oral nutritional support

In the current financial climate, the challenge is to deliver efficiency savings more than ever before. One key area where AHPs can clearly demonstrate both cost and quality improvements is the management of malnutrition. The AHP QIPP oral nutritional support toolkit highlights the key role of dietitians as clinical leaders in the system (NHS London, 2012). Robust service delivery models across care sectors will ensure that people access the right care at the right time, and reduce inappropriate prescribing of oral nutritional supplements. Dietitians have an essential role in leading different disciplines to establish robust policies, processes and care pathways that prevent, identify and treat malnutrition across health and social care. Improving nutritional care can reduce admissions and readmissions, shorten hospital stays, and – crucially – fulfil an important public health function in reducing health inequalities.

Medicines management and dietetics have worked collaboratively to identify and implement strategies to improve the identification and treatment of malnutrition and improve prescribing in outer north-east London. Strategies include employing senior dietitians to advise on the supply and administration of oral nutritional supplements. Since this initiative, expenditure across the area has been on a downward trajectory, with a saving of £261,122 (12 per cent) in 2011–12 compared to a rise of almost £200,000 (10 per cent) in 2010–11 (NHS London, 2012).

9 Making the most of AHPs to support integrated care and pathways

Integration of services is at the heart of current reforms in health and social care. The Health and Social Care Act (2012) places duties on health and wellbeing boards and clinical commissioning groups to promote joined-up care. A care pathways approach that focuses on the AHP workforce to deliver safe, effective and efficient care will play a significant role in realising the ambitions for truly integrated care and delivering the QIPP agenda.

AHPs are the essential integrators of care. Their collaborative model of working sees them educating, training and enabling a significant number of support staff, as well as people using services and carers. Advanced practitioners in particular continue to make progress in smoothing out care pathways, cutting unnecessary steps and ensuring diagnostics or treatment take place at the right level. AHPs play a key role across integrated care pathways:

- Prevention – AHPs provide advice such as falls prevention and smoking cessation advice to support people using services, their families and carers to avoid developing illnesses or readmission to hospital.
- Cure – AHPs deliver primary interventions, diagnose and treat ill health. For example, they deliver nutritional support following surgery to enhance healing and increase independence.
- Rehabilitation – AHPs optimise the functional capacity of people in their care, such as speech and language therapy following a stroke.
- Support – AHPs educate and support people to live their lives the way they choose to. For example, occupational therapists enable people to return to work.

AHPs are well placed to bridge the gap between primary and secondary care, in particular in expediting discharge and preventing readmission while also optimising return to health.

A CfWI programme of work examining workforce requirements across care pathways for later life has been extended across other pathways (CfWI, 2011). For more information visit the CfWI care pathways website: www.cfwi.org.uk/care-pathways. Working with Mouchel Health, with support from the CfWI, the National Cancer Rehabilitation Advisory Board, professional bodies and cancer networks have further developed the workforce pathways tool to enable commissioners and providers to understand the rehabilitation workforce needed to support people affected by cancer. The pathways tool demonstrates how the AHP workforce can be deployed along pathways with a particular focus on addressing unmet need rather than calculating absolute workforce numbers. The model has been issued to all cancer networks in England (National Cancer Action Team, 2012).

Making the most of AHPs working in diabetes care

AHPs make a significant difference in improving clinical outcomes for people affected by diabetes. This rapidly growing long-term condition can have complications affecting sight, limbs and independence. For example, the annual cost to the NHS of diabetic foot ulcers in England alone is estimated at £474–619 million, with a mid-range estimate of £574 million (Kerr 2012).

AHPs work both in uni-professional teams and demonstrate their advanced skills in diabetes care in multidisciplinary teams. Podiatrists, for example, working as part of a coordinated foot protection team, can achieve impressive outcomes such as reducing foot ulcer rates, reducing amputations and contributing to cost savings (Kerr, 2012).

Making the most of AHPs working in stroke care

Radiographers working with speech and language therapists use videofluoroscopy techniques to diagnose and assess a range of eating and swallowing problems.

The AHP QIPP stroke toolkit demonstrates how the use of radiographers to improve the skill mix can have a measurable impact on the quality and efficiency of stroke services. For example, at Glasgow Royal Infirmary clinic costs were reduced from £345 using a consultant radiologist and a speech therapist to £215 by using a radiographer and speech therapist. At five videofluoroscopy clinics per week, the annual saving for the hospital was £33,800 by implementing speech and language therapist-led videofluoroscopy clinics. There is potential for national annual savings to the NHS of £4.191 million (NHS London, 2012).

Key messages

- Making better use of AHPs improves outcomes for people and makes better use of finite resources.
- The skill mix of AHPs adds value and improves outcomes across care pathways.
- Making better use of support workers and assistant practitioners enables AHPs to do more of what they are uniquely qualified to do.
- Effective clinical leadership is one of the key enablers to harness the potential of the AHP workforce, as leadership is required to drive collaboration, research, evidence-based care and involvement.
- Incentivising practice placements and focusing on the importance of the practice educator role during commissioning can help to ensure that there are enough high-quality practice placement opportunities for AHPs.
- Maintaining and sustaining a high-quality AHP academic workforce skilled in clinical research is essential to secure high-quality education and training.
- Preceptorship is a model of workforce enhancement that can help to ensure that the system has confident practitioners to work in new and emerging models of care delivery.
- Making better use of advanced practitioners could help to meet the QIPP transformation challenge by leading innovation through research and development, improving productivity by leading service redesign, and preventing both admissions and readmissions to hospital.
- AHPs can be pivotal in supporting integrated care and have a key role to play in prevention, cure, rehabilitation and support across integrated care pathways.

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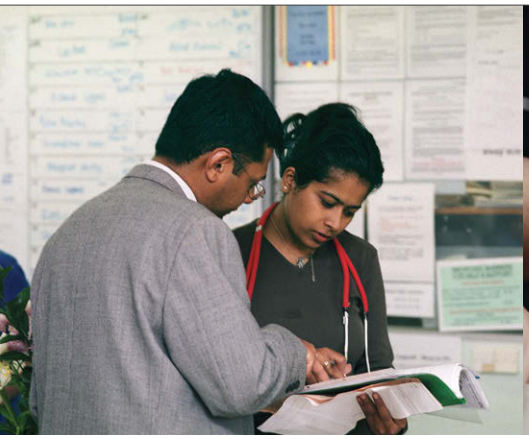
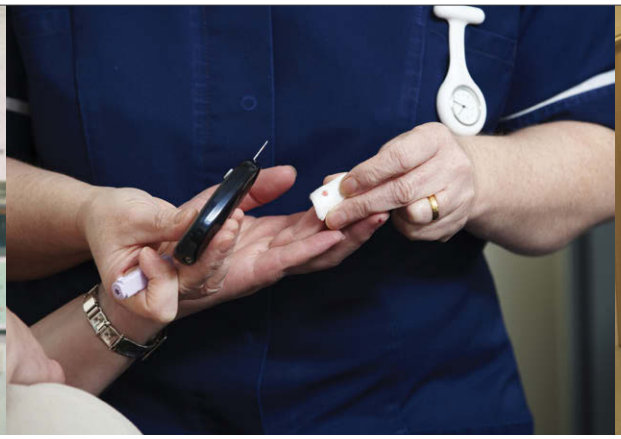


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Why the AHP workforce matters: the perspectives of experts by experience

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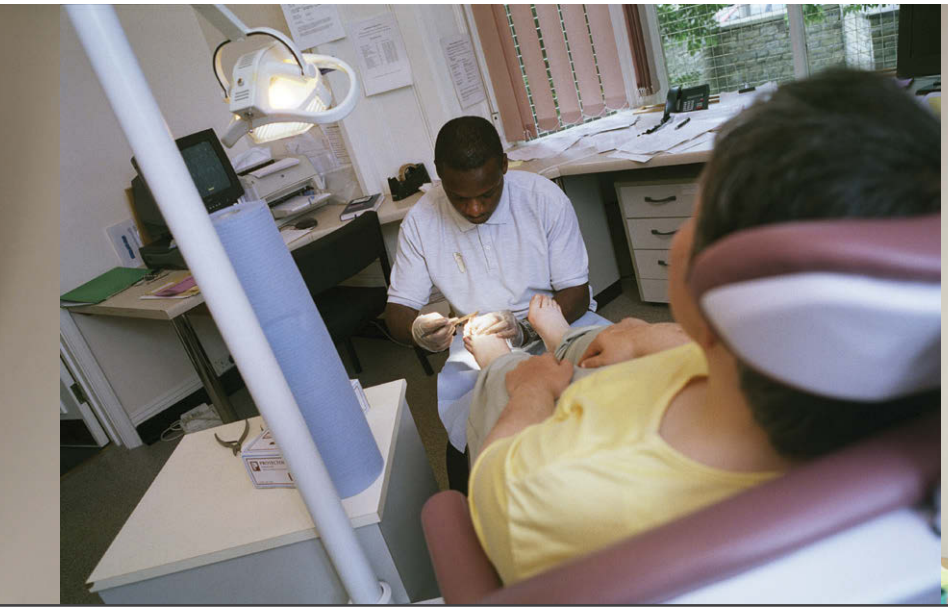
Carer

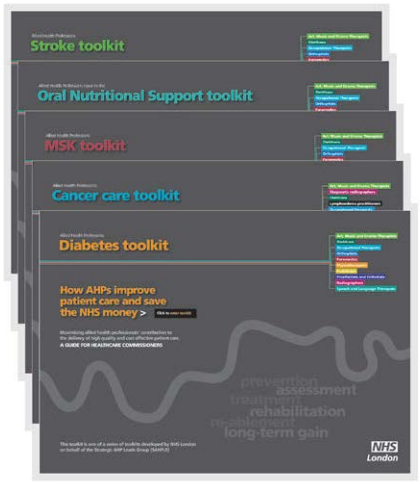


2 Quality, innovation, productivity and prevention (QIPP): the workforce implications for the allied health professions

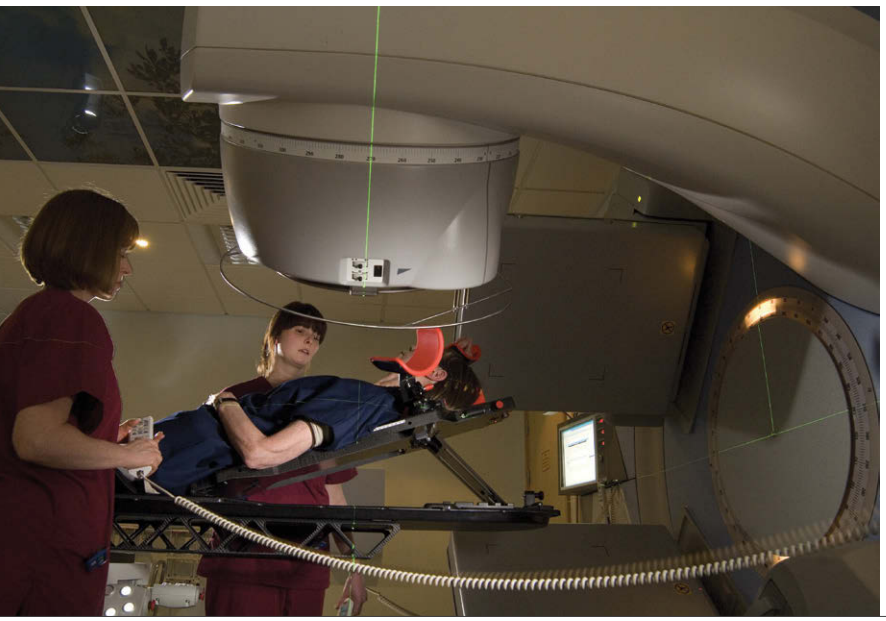
QIPP is a large-scale transformation agenda for the NHS workforce and its partners. To support the QIPP agenda for AHPs, NHS London (2012) working with the Strategic Allied Health Professionals Group, produced a series of toolkits, *How AHPs improve patient care and save the NHS money*. The toolkits were prepared on behalf of the Strategic Allied Health Professionals Leads and partially funded by the national AHP Professional Advisory Board.

How AHPs improve patient care and save the NHS money. Find out more at: www.networks.nhs.uk/nhs-networks/ahp-networks/ahp-qipp-toolkits

The AHP QIPP toolkits are an online, interactive resource demonstrating how better use of AHPs improves care and outcomes for people while making better use of finite resources. The toolkits are targeted at commissioners and clinicians and clearly illustrate how AHPs add specific value along care pathways, demonstrating at each stage how AHP interventions improve outcomes while making better use of resources.



Improvements to care and reductions in costs through the use of AHPs can be identified along each care pathway. The five care pathways examined in the QIPP toolkits are: cancer, diabetes, musculoskeletal disorders, oral nutritional support and stroke.



3 Making the most of support workers and assistant practitioners

Support workers and assistant practitioners have a key role to play in healthcare (Skills for Health, 2011a), and can support improved skill mix for AHPs (Lizarondo et al., 2010). They can take on tasks that would otherwise be delivered by registered staff, freeing staff to deliver what they have been trained for. Using support workers and assistant practitioners as part of the skill mix of a team can therefore further enable the development of advanced practitioners and consultant AHP roles.

Support workers and assistant practitioners work alongside AHPs in specific roles such as physiotherapy support work, or across pathways such as in diabetes care. However, much more could be made of both uni-professional and multi-professional support workers and assistant practitioners.

Historically there has been limited research on the impact of AHP staffing levels on clinical outcomes (Cartmill et al., 2012) and, more generally, not enough is known about how best to use support workers and the impact of changes in skill mix and roles (SDO Network & NHS Confederation, 2011).

However, the emerging evidence suggests that such roles can improve clinical and service outcomes (Griffin and Sines, 2012). For example, Skills for Health (2011b) describes how the introduction of two clinical therapy assistant roles led to reduced lengths of stay for older people and people who have had a stroke at the Whittington Hospital NHS Trust.

Making the most of assistant practitioners working in orthopaedic therapy

Band 4 therapy technicians in the orthopaedic therapy team at Southampton General Hospital have taken a lead role in pre-operative education classes since the introduction of the enhanced recovery programme (ERP) for elective total hip replacements and knee replacements in 2011.

Due to their dual training in occupational therapy and physiotherapy, support workers are well placed to answer queries. The education classes provide information and advice on surgery and rehabilitation. This is an invaluable service, which has received positive feedback as it prepares people for their surgery and empowers them to be actively engaged in their recovery. Since the introduction of the ERP, the length of stay has decreased and user satisfaction increased.

4 Making the most of pre-registration education

Entry into the allied health professions is predominantly at BSc (Hons) level with the exception of paramedics, who may take a diploma or foundation degree, and the arts therapies, where entry to the profession requires a masters qualification. The length of pre-registration programmes varies, but is usually three or four years as an undergraduate and two years as a postgraduate student. Some postgraduate programmes have been introduced that enable graduates with a relevant first degree to undertake a shorter pre-registration programme at postgraduate level.

With the wholesale changes in health service organisation, including the establishment of Health Education England and local education and training boards, there is a risk that practice placements for AHPs may become less available. This is especially true with the advent of the any qualified provider policy, with no incentive for new providers to offer such placements. This is already evident in the provision of musculo-skeletal placements for physiotherapists and community placements for speech and language therapists. The allocation of some funding to follow all non-medical healthcare students on placement is welcomed, though this has been set at a low level and may not necessarily cover the costs of providing these placements. Obtaining an adequate quantity of high-quality practice placements is critical to the development of AHP roles, both today and in the future. It is important to ensure placements continue to be offered to students, despite the present economic climate. Incentivising placements could help to embed the importance of high-quality placements.

Practice educator training is not mandatory in allied health, but some of the AHP professional bodies, including the College of Occupational Therapists, Society and College of Radiographers, Chartered Society of Physiotherapists and Society of Chiropodists and Podiatrists, provide nationally accredited programmes (Department of Health and Skills for Health, 2008). It is important to recognise the significance of practice educators in maintaining and improving the quality of placements, as service delivery models change and respond to personalisation and the extension of choice.

Making the most of AHPs by using 'role-emerging placements' in occupational therapy

'Role-emerging placements' have been championed by the College of Occupational Therapists. This has led to innovation in practice placements for occupational therapy students. In particular, private and voluntary organisations, where there is not an established occupational therapy role, take students to explore the potential for occupational therapy with long-arm supervision, either from the university or an occupational therapist in another organisation (Department of Health, 2011).

5 Making the most of AHPs as clinical academics

The academic workforce is critical to ensuring the future supply of AHPs. The first report from the NHS Future Forum on education and training stated that 'healthcare education and training must deliver excellence in practice' (DH, 2012a). The subsequent development of the draft education outcomes framework highlighted the need for high-level strategic workforce planning, education and training alongside professional development, research and innovation (DH, 2012b). The success of these new developments for services delivered by AHPs is dependent on an academic workforce that is fit for purpose.

It is important to maintain a focus on the contribution the AHP academic workforce can make to care through teaching and research. In particular, when workforce planning, it is important to take into account the sustainability of the academic workforce. Smaller professions, where reductions in education commissions could lead to programmes becoming untenable, could result in a loss of academics from the system. The priority for improving outcomes for people is to secure high-quality education, training and research by maintaining and sustaining a high-quality research-skilled academic workforce.

The current trends towards reduced education commissions for most AHPs could mean that any future shortfall in academic staffing may not be quickly recovered if education commissions increase. As services are redesigned and clinical lead posts are removed, it may become increasingly difficult for AHPs to develop academic and research careers. The National Clinical Academic Training Pathways are beneficial in supporting the work being done locally to develop clinical academics (www.nihrtcc.nhs.uk). Further improvements include joint posts between universities and services to further promote the translation of academic research into practice, alongside role modelling for AHPs wanting to develop their academic careers. In turn, these posts should also improve the quality of education provided.

The National Institute for Health Research (NIHR) offers a number of different research training programmes for AHPs who aspire to develop their academic career. The most notable is the Clinical Academic Training Programme, which operates at four levels: Masters in Clinical Research; Clinical Doctoral Research Fellowship; Clinical Lectureship and Senior Clinical Lectureship. AHPs have performed well in securing these prestigious awards, particularly at the Clinical Doctoral Research Fellowship level.

The current economic climate may lead higher education institutions to rethink learning opportunities, with more teaching and learning being offered online. It is important to avoid a situation of 'dry land' education where students seldom get the opportunity to learn in a real clinical setting.

Making the most of AHPs with joint appointments

Joint lecturer practitioner posts can work well to ensure integration between practice and education. In the School of Rehabilitation Sciences, Faculty of Health, Social Care and Education, a partnership between Kingston University and St George's, University of London, a Band 7 physiotherapist works in acute respiratory care as a lecturer on the pre-registration BSc and MSc physiotherapy programmes run by the school. This ensures practice and education are informed by each other and increasingly work together to ensure the best practitioners are educated. Both clinical and academic staff are seeing the benefit of this approach.

6 Making the most of preceptorship

Preceptorship is a structured transition phase allowing newly qualified AHPs to develop their confidence and apply knowledge, skills and competences acquired as students to their area of practice, laying a solid foundation for life long learning. Preceptorship should be seen as a model of enhancement, which acknowledges new graduates and registrants as safe, competent but novice practitioners who will continue to develop as part of their career development and continuing professional development (Department of Health, 2010a).

A number of the allied health professions, notably occupational therapy and orthoptics, have well-established models of preceptorship delivered through professional bodies (Department of Health, 2011). Preceptorships in allied health can be valuable in embedding leadership development and research into the AHP culture, as well as ensuring that the system has the confident practitioners it needs to work in new and emerging models of care delivery.

Access to preceptorship is not uniform across the professions, particularly where employment models are predominantly outside the NHS, for example prosthetists and orthotists. A potential solution could be for preceptorship to be included in future commissioning arrangements.

Making the most of occupational therapists through preceptorships

The London mental health professional lead occupational therapy group, on behalf of the College of Occupational Therapists, devised a preceptorship programme to support new practitioners as they start work. The programme supports career progression to advance clinical reasoning. This increases clinicians' confidence and competence to deliver better outcomes and experiences for people using services (College of Occupational Therapists, 2012).

7 Making the most of advanced practitioners

Making better use of advanced practitioners and consultants is a potentially key element of meeting the QIPP agenda by:

- improving the quality of services by advancing practice
- leading innovation through research and development
- improving productivity by leading service redesign
- leading prevention and preventing both admissions and readmissions.

Advanced practice roles enhance the prospect for career progression and attract more high-quality applicants to the professions. Where no advanced practice roles exist, it is more difficult to recruit and retain high-quality staff (Department of Health, 2010b). Advanced practice roles can form part of the 'psychological contract' that motivates employees and creates higher job satisfaction and the willingness of staff to contribute over and above their 'core contract'. In turn, AHPs can develop the competences associated with advanced practice roles.

Advanced practitioners will have competences that overlap with other professions and grades, and this provides opportunities for substitution: that is, an advanced practitioner carrying out a task which would otherwise be carried out by another clinician. These tend to allow for the optimum use of existing resources.

Making the most of AHPs by diagnosing fractures

NHS Employers (2011) describes how South Tyneside NHS Foundation Trust has demonstrated the benefits and positive outcomes on service delivery through advanced practice. The trust implemented a strategy where all its radiographers carry out initial reporting; and failure to diagnose fractures in the trust decreased steadily from 7.3 per cent in 2002 to 0.7 per cent in 2010, thereby improving outcomes for people and reducing accident and emergency waiting times. This approach encourages multidisciplinary working and provides staff with enhanced career development.

Making the most of AHPs working with people affected by musculoskeletal disorders

The musculoskeletal disorders toolkit shows how extended scope practitioner role development can improve outcomes and save money. Extended scope occupational therapy (hand therapy) services has been developed at Guy's and St Thomas' Hospital and includes diagnosis assessment and planning treatment up to surgery if required. People can be seen after two weeks rather than waiting 12 weeks for a consultant appointment (NHS London, 2012).

8 Making the most of AHPs as clinical leaders

Strong clinical leadership across all of the AHPs can be used to drive improvements in service delivery and enhance the quality of care for people using services. Effective clinical leadership is one of the key enablers to harness the potential of the AHP workforce, as leadership is required to drive collaboration, research, evidence-based diagnosis, treatment and care.

The AHP career framework takes a competence-based approach to service delivery, meaning that the right person with the right skills provides the right care (Department of Health 2008). AHPs' clinical skills can be developed and transferred into leadership roles. By taking a competence-based approach to leadership, AHPs will have more transparent opportunities to move into leadership roles, thereby removing some of the current barriers from the system and releasing diverse leadership talent. This will maximise creativity and drive up both quality and productivity, while also increasing the visibility of AHPs, especially among the smaller professions.

The development of clinical commissioning groups and clinical networks and senates provides opportunities for AHPs to use their leadership skills to demonstrate the contribution of the whole AHP workforce across care pathways (Keogh and Dalton, 2012). However, for this to be effective there needs to be a strong AHP voice, rather than uni-professional representation. Inter-professional learning and education, from pre-registration level onwards, will support this alongside effective clinical leadership.

Service redesign should include effective clinical and professional leadership at an appropriate level to ensure services have the right skill mix. Clinical leaders, supported through multi-professional development opportunities, can move away from traditional programmes of delivery to include action learning, mentoring and coaching. In addition to this, talent management systems should support succession planning strategies for emerging clinical leaders to be developed.

Making the most of AHPs working in oral nutritional support

In the current financial climate, the challenge is to deliver efficiency savings more than ever before. One key area where AHPs can clearly demonstrate both cost and quality improvements is the management of malnutrition. The AHP QIPP oral nutritional support toolkit highlights the key role of dietitians as clinical leaders in the system (NHS London, 2012). Robust service delivery models across care sectors will ensure that people access the right care at the right time, and reduce inappropriate prescribing of oral nutritional supplements. Dietitians have an essential role in leading different disciplines to establish robust policies, processes and care pathways that prevent, identify and treat malnutrition across health and social care. Improving nutritional care can reduce admissions and readmissions, shorten hospital stays, and – crucially – fulfil an important public health function in reducing health inequalities.

Medicines management and dietetics have worked collaboratively to identify and implement strategies to improve the identification and treatment of malnutrition and improve prescribing in outer north-east London. Strategies include employing senior dietitians to advise on the supply and administration of oral nutritional supplements. Since this initiative, expenditure across the area has been on a downward trajectory, with a saving of £261,122 (12 per cent) in 2011–12 compared to a rise of almost £200,000 (10 per cent) in 2010–11 (NHS London, 2012).

9 Making the most of AHPs to support integrated care and pathways

Integration of services is at the heart of current reforms in health and social care. The Health and Social Care Act (2012) places duties on health and wellbeing boards and clinical commissioning groups to promote joined-up care. A care pathways approach that focuses on the AHP workforce to deliver safe, effective and efficient care will play a significant role in realising the ambitions for truly integrated care and delivering the QIPP agenda.

AHPs are the essential integrators of care. Their collaborative model of working sees them educating, training and enabling a significant number of support staff, as well as people using services and carers. Advanced practitioners in particular continue to make progress in smoothing out care pathways, cutting unnecessary steps and ensuring diagnostics or treatment take place at the right level. AHPs play a key role across integrated care pathways:

- Prevention – AHPs provide advice such as falls prevention and smoking cessation advice to support people using services, their families and carers to avoid developing illnesses or readmission to hospital.
- Cure – AHPs deliver primary interventions, diagnose and treat ill health. For example, they deliver nutritional support following surgery to enhance healing and increase independence.
- Rehabilitation – AHPs optimise the functional capacity of people in their care, such as speech and language therapy following a stroke.
- Support – AHPs educate and support people to live their lives the way they choose to. For example, occupational therapists enable people to return to work.

AHPs are well placed to bridge the gap between primary and secondary care, in particular in expediting discharge and preventing readmission while also optimising return to health.

A CfWI programme of work examining workforce requirements across care pathways for later life has been extended across other pathways (CfWI, 2011). For more information visit the CfWI care pathways website: www.cfwi.org.uk/care-pathways. Working with Mouchel Health, with support from the CfWI, the National Cancer Rehabilitation Advisory Board, professional bodies and cancer networks have further developed the workforce pathways tool to enable commissioners and providers to understand the rehabilitation workforce needed to support people affected by cancer. The pathways tool demonstrates how the AHP workforce can be deployed along pathways with a particular focus on addressing unmet need rather than calculating absolute workforce numbers. The model has been issued to all cancer networks in England (National Cancer Action Team, 2012).

Making the most of AHPs working in diabetes care

AHPs make a significant difference in improving clinical outcomes for people affected by diabetes. This rapidly growing long-term condition can have complications affecting sight, limbs and independence. For example, the annual cost to the NHS of diabetic foot ulcers in England alone is estimated at £474–619 million, with a mid-range estimate of £574 million (Kerr 2012).

AHPs work both in uni-professional teams and demonstrate their advanced skills in diabetes care in multidisciplinary teams. Podiatrists, for example, working as part of a coordinated foot protection team, can achieve impressive outcomes such as reducing foot ulcer rates, reducing amputations and contributing to cost savings (Kerr, 2012).

Making the most of AHPs working in stroke care

Radiographers working with speech and language therapists use videofluoroscopy techniques to diagnose and assess a range of eating and swallowing problems.

The AHP QIPP stroke toolkit demonstrates how the use of radiographers to improve the skill mix can have a measurable impact on the quality and efficiency of stroke services. For example, at Glasgow Royal Infirmary clinic costs were reduced from £345 using a consultant radiologist and a speech therapist to £215 by using a radiographer and speech therapist. At five videofluoroscopy clinics per week, the annual saving for the hospital was £33,800 by implementing speech and language therapist-led videofluoroscopy clinics. There is potential for national annual savings to the NHS of £4.191 million (NHS London, 2012).