

Our NHS our future: NHS Next Stage Review

AHPs as Integrators of Care

Report of the key findings from the
Allied Health Professions Federation event

April 2008



Health Professions Federation

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Introduction

As part of the national stakeholder engagement process for the Our NHS, Our Future Review in England, Professor the Lord Darzi KBE, Parliamentary Under-Secretary of State for Health, requested the opportunity to meet with the Allied Health Professions. This event on 25 March, 2008 provided an opportunity for Allied Health Professionals (AHPs) to promote their combined and individual unique contributions to health and well-being service delivery.

The conference showcased innovation in service delivery from 5 different AHP services, all of which made specific contributions to the 4 broad themes of:

- access
- dignity and the patient as a person
- integrating care and partnership
- choice and personal control

identified in Lord Darzi's Interim Report published in October 2007.

The conference also explored how AHPs can, and are already developing high quality, user focussed services within the community and acting in clinical leadership roles. Other areas debated were the barriers to further development of AHP services and how these might be addressed, the structure of the workforce, skills transferability and how all stakeholders benefit from sharing knowledge and expertise across traditional professional boundaries.

This report is a composite of the conversations and exemplars of innovative AHP practice discussed on the day and seeks to identify clearly the key messages about the substantial contribution that all the AHPs already make, but more importantly the untapped potential within this highly skilled workforce to deliver a much greater impact across the whole health and well being economy.

The report locates under each of the 4 key themes from the Interim Report what contribution AHPs may offer, illustrated by an example case study. It is of note that there is obvious and substantial cross over within and across themes and all case study examples could be used to illustrate all themes; further illustration that AHPs are ideally suited as both clinical leaders, integrators of care and can ably achieve the ambitions for the NHS for the next ten years.

Who are the AHPs?

The Allied Health Professions are 11 different professional groups regulated by the Health Professions Council. While acting as independent professions with their own professional bodies, these professions are also united through an umbrella body, the Allied Health Professions Federation (AHPF). This showcase event was situated within the AHPF rather than individual professions.

Executive Summary

Using the 4 key themes (access, dignity and the patient as a person, integrating care and partnership, choice and personal control)¹, the event identified numerous key attributes, both current and potential, of AHPs to health and well-being services.

Access

- Direct access/self-referral to AHP services can considerably reduce waiting times for access to services, improve patient satisfaction with a reduction in the 'referral merry go-round' and better assist patients to manage their conditions thereby reducing the development of co-morbidities.
- AHPs have the clinical, leadership and managerial capabilities to lead, and do lead, key areas of services, especially related to long term conditions, co-ordinating activity across multi-agency settings, ensuring integration of high quality services. AHPs leading condition management pathways sign-post users to other services

rather than merely acting as a gate-keeper, whereby they can facilitate, engage with and empower the service user and enhancing their overall experience, for instance through a 'one-stop shop' arrangement.

Dignity and the patient as a person

- In services led by AHPs the focus is strongly on capability and potential. This has a positive impact enabling service users to recognise they possess skills at a variety of levels, and a return to purposeful activity is not always about return to paid employment in the traditional sense².
- AHPs, with their holistic, person centred approach to health and well-being, are ideally placed to lead the delivery of services requiring long term support, regardless of setting, with improved continuity of care, solving gaps in service delivery, and producing education strategies. Patient outcomes can be significantly improved by the provision of timely information and appropriate aftercare and rehabilitation.

Integrating care and partnership

- Necessarily, the NHS is increasingly focussed around individual responsibility for personal health and well-being. The philosophy of care of AHPs is a bio-psychosocial model underpinned by enabling service users, patients and carers to learn how to manage their own situation and condition more effectively. AHP led multi-professional rehabilitation programmes produce long term cost effectiveness.
- The benefits of AHP clinical leadership also lie in

¹ These themes were identified within *Our NHS, Our Future* Interim Report, October 2007

² *Working for a Healthier Tomorrow* – Dame Carol Black's Review of the health of Britain's working age population, March 2008

ensuring a seamless transition from one stage to the next along a care pathway, addressing both physical and psychological impacts, with an improved service user outcome. The advent of supplementary prescribing rights has allowed the redesign of a number of services to better integrate provision.

Choice and personal control

- By working closely with service users, AHPs act as key 'sign posters' and are able to conceptualise the whole journey for the patient. AHPs can advocate for service users, bring a solution focus to individual patient need rather than just a clinical diagnosis, enabling patients to make informed choices and helping them to understand and balance the risks within the decision making process.
- There are many examples where AHPs have extended their roles into areas more traditionally recognised as being held by medical practitioners, such as in diagnosis. Upskilling of AHPs at a consultant level can further enhance the service with improved user experience due to better continuity and decreased costs.
- Due to their empowering relationship with service users, AHPs are able to educate and support service users to develop and sustain new positive health behaviours much more effectively.
- Social inclusion is a fundamental tenet of well-being and AHPs already have the skills and knowledge to engage and lead community group activities to promote inclusion. This has recognised benefits for the demand on health services.

- The NHS requires flexible and competency based workforce planning which needs to be more evidently and consistently linked with new models of care and with financial and service planning at all levels in the system. Education and training providers must also be involved to deliver the required skills and competencies.



Access

Key concepts

- Direct access/self-referral to AHP services
- AHPs working flexibly
- More services under one roof

For acute need:

Speech and language therapists, physiotherapy and occupational therapy have for many years engaged in direct access or self referral for patients. Traditionally for physiotherapy this has been primarily within musculoskeletal services, for occupational therapy it is most common within the social services sector, in speech and language therapy substantial work takes place within early years settings and schools.

Self-referral to physiotherapy has identified the positive benefits of such systems. In Somerset PCT, as a result of patient self-referral to physiotherapy, waiting times have plummeted from 20 weeks to 3 or 4 while urgent appointments are seen within 48 hours. Not surprisingly patient satisfaction has substantially increased. Data suggests that the majority of patients are managed within the physiotherapy out-patient clinic, with only 1% needing to return to their GP for further specialist support. Some 75% of patients only required one or two physiotherapy sessions, with over 50% saying they were completely better or significantly improved as a result of their consultation. One-third indicated that their condition was largely unchanged.

Maximising the use of appropriate self-referral or direct access, particularly in the management of

musculoskeletal problems prevents the 'merry-go-round' between GP, consultant and physiotherapist that many patients suffer in seeking treatment for commonly encountered musculoskeletal problems. In the Somerset pilot some 38% of service users were over 65 years of age and 70% of these had problems of at least 3 months standing, 50% being spinal problems.

If this scenario is extrapolated, a 20 week wait for a first appointment for help with a spinal problem may incur the development of other concurrent musculoskeletal problems. Such complex co-morbidities may result in a greater need for other expensive health and/or social care support services. By investing resources to manage the problem at source and empowering the patient to live with their problem and prevent further problems developing, the economic argument for self-referral is irrefutable. Over 90% of those seeking treatment through the self-referral pilot in Somerset agreed that physiotherapy offered effective treatment for musculoskeletal problems and a similar proportion felt that patients could learn a lot about managing their health problems.

For self management within a long term condition pathway:

An AHP led scheme in Bradford is helping people with long-term conditions. This scheme has already been shown to be effective for service users with multiple sclerosis, and is now being rolled out for those with chronic obstructive pulmonary disease(COPD) and in the management of chronic pain. The guiding principle for this scheme is that the services are designed around the

patient and reflect what the patient wants. People are able to access the multi-disciplinary team when they feel their condition is changing. It is well known that people with long-term conditions mostly face a confusing maze in order to access statutory services. Accessing the right service at the right time in their situation means that further problems will most likely be prevented. This is most especially true in the prevention of re-admission for conditions such as COPD, or indeed the flare up of a joint in a person with rheumatoid arthritis. The Bradford programme gives service users access to all appropriate AHP services as well as a specialist nurse, psychologist and employment adviser.

Ensuring the focus of service is on what the service user identifies as their need, maximising the effectiveness of the service for example a service user with obvious physical need may say their need is with housing or benefits, or getting into the bath. The AHP led condition management pathway acts as a sign- posting route to services rather than as a gate keeper. It is therefore facilitative, engaging and empowering the service user, enhancing the patient experience.

The Bradford conditions management programme model clearly demonstrates that AHPs have the clinical and managerial capabilities to lead key areas of services, especially related to long-term conditions and co-ordinate across multi-agency settings, ensuring integration of high quality services. While this programme is based on what the service users identify as their need, and gives access to a multi-professional team, service users experience a co-ordinated approach to care from a team who share their knowledge and skills for best service user effect.

Such a service is highly transferable to other settings

and is the foundation of a long-term conditions centre. This would act as a 'one-stop shop' for all patient needs, including disability and employment advice, pharmacy and equipment as well as providing a focal meeting point for those experiencing social isolation so often associated with living with a long term condition.

Other routes to improved access are situated in the potential flexibility and adaptability of the AHP workforce. There are issues around the impact of payment by results, complexity of unbundling and a lack of clarity about the tariff and perverse incentives associated with decreased income.

The development of fully funded extended hours or seven day working in appropriate AHP services, the use of telephone triage services such as PhysioDirect in Huntingdon PCT; maximising the use of alternative providers and the development of the e-health agenda and telemedicine are all facets of improving access in which AHPs have some engagement. Full engagement with such agendas requires cultural evolution and investment of resources.

Dignity and the Patient as a Person

Key concepts:

- AHPs shaping community health and well-being services
- AHPs enhancing patient experience
- AHPs as clinical leaders

Services in mental health

Service delivery in support of mental health is identified as one of the 8 strands within the NHS Review interim report. AHP led community based services in north-east London have succeeded in placing some 50 people with mental health problems into education and training, 94 into unpaid work and 45 into paid employment. This project, launched in 2006 responded to the issues raised by Government about the social exclusion experienced by mental health service users and the possibility that the current philosophies for service delivery proved more barrier than enabler for this user group. A long held belief of many healthcare professionals has been that work is a threat to mental stability rather than an aid to recovery. The recent report from Dame Carol Black also highlights the tangible benefits of return to work – not necessarily defined as paid employment. The knowledge that 600,000 people of working age population move on to incapacity benefit each year, brings a timely reminder that changing the philosophy underpinning the delivery of service in mental health will have a positive impact on service users as individuals, collectively and ultimately on the whole health economy. Taking the step of commissioning such care pathways across sectors, i.e. across health, social care, and where appropriate education can only



facilitate the establishment of such person centred services.

Covering 2 London PCTs and 7 London Boroughs working in partnership with a range of other organisations such as London South Bank University, the Learning and Skills Council and Job Centre Plus, this occupational therapy consultant led service is about linking service users with local work opportunities, providing the appropriate vocational support. The occupational health services are integrated into this

whole organisation approach.

Feedback has indicated that the change in focus to recognition of capability and potential has had a positive impact with service users recognising that they possess skills at a variety of levels, and return to useful activity is not always about return to paid employment in the traditional sense.

Services in cancer care

The recent advances in cancer care have now successfully moved cancer and its management into a long-term condition. AHPs, with their holistic, person centred approach to health and well-being, are well placed to lead the delivery of cancer services for the long term support, but are also well placed to lead such services within the acute sector. This is illustrated by the services for women undergoing internal radiotherapy, led by a specialist gynaecological therapy radiographer from Cambridge University Hospitals NHS Foundation Trust. The evidence available at the time this project was started indicated that patient outcomes were significantly improved by the provision of timely information and appropriate aftercare. This service demonstrates the pivotal role that can be adopted by therapy radiographers to positively influence, identify, implement and evaluate change to enhance delivery of high quality patient focussed services within the cancer pathway. Another component of this service is the potential for the implementation of the role of a radiotherapy community liaison practitioner. It is anticipated that such a post would have a strategic focus based in the community or the wider cancer network, providing improved continuity of care, identifying gaps in service and producing education strategies.

Services for long term conditions

Clinic at Home is an AHP led multi-disciplinary community service to meet the needs of patients with long standing rheumatoid arthritis. The Clinic at Home service was set up to meet the complex needs of these individuals with a member of the multi-disciplinary team visiting a patient in their own home. On such visits the service user is assessed against agreed service and clinical criteria and a care package agreed that can be delivered at home. The benefits of such a service are that some 68% of problems are solved during the visit, 32% of problems requiring further investigation are usually solved within 2 weeks and 100% of visits are deemed appropriate by both service users and staff.

Integrating Care and Partnership

Key concepts:

- The role of AHPs in preventing ill health
- Sharing the responsibility for preventing ill health and promoting well-being
- AHPs as integrators of health and well-being services
- Incentives for change

The model of care provided by AHPs is a bio-psychosocial model underpinned by enabling service users, patients and carers to learn how to manage their own situations more effectively. Necessarily, the NHS is increasingly focussed around individual responsibility for personal health and well-being. AHPs are ideally suited to deliver within this context as their therapeutic interventions are embedded in an empowerment model,

supporting service users to develop an internal locus of control with regard to their own health and well-being.

Services for Chronic Obstructive Pulmonary Disease (COPD)

Central to many of the public health initiatives is activity and exercise. Regular exercise has been shown to cut heart disease by one third, strokes and Type II diabetes by a quarter and hip fractures in older people by half.

COPD is recognised as the second most common cause of emergency admission to hospital. AHP led multi-professional pulmonary rehabilitation programmes are already showing evidence of prevention of readmission to hospital and with more service users knowledgeably self caring and maintaining themselves economically active, the case for investment in such management programmes is strong. Such programmes have an educational and prevention element incorporated, both to prevent relapse and remission and also to prevent the development of co-morbidities. The Lambeth and Southwark PCT pulmonary rehabilitation programme has the capacity to see approximately 430 patients per annum, but there are approximately 5000 people in the area diagnosed with COPD, plus in the region of another 5000 people as yet undiagnosed. Establishing through these rehabilitation programmes a simple lung function assessment process as a 'well person check' for smokers and explaining the results in terms of 'lung age' is known to improve the effectiveness of smoking cessation strategies. This would have a direct benefit on health and well-being of a substantial community.

Incentives for change

The incentive for investment in AHP led multi-professional pulmonary rehabilitation programmes is the long term cost effectiveness. Such programmes incorporate opportunity for engagement with the long term benefits of physical activity, occupational recovery and employment support, understanding special dietary requirements to maximise respiratory muscle function, orthotic or podiatric support and as well as psychosocial support. Provision of such services would impact not only on the individual in terms of quality of life and reduced risk of co-morbidities associated with COPD, but also: economically on the prescriptions budget, social services support in terms of adaptations to home, provision of aids and benefits, and in terms of economic benefits to society within the working age population through the payment of taxation.

Providing a 'wellness service'

Managing the mental health impact of living with a long-term condition is complex and affects not just the patient but their carers and supporters as well. An art therapy project has been set up between Oxleas NHS Foundation Mental Health Trust and Tate Britain encouraging service users and their carers to study and discuss their feelings about particular paintings as a route to rehabilitation. While the focus is currently for use with those with primary mental health problems, the use of art to 'recalibrate' the mind and help achieve a mental health balance cannot be under-estimated. The AHP leading this project identifies that art therapists could act as a bridge

from 'injury to activity' as many people use involvement in the arts to maintain their sense of wellness. Such a sense of wellness is a major contributor in achieving maximal functional capacity for all individuals whether recovering from an acute injury or learning to live with a long-term condition.

AHP clinical leadership for service integration

A diagnosis of cancer will take the patient on a journey through primary, secondary and tertiary care. Issues surrounding continuity of care can be all too apparent as the patient moves along the pathway. Co-ordinated, patient led care from the point of diagnosis facilitates

a seamless transition from one stage to another. Currently in the UK there are no centres offering a multi-professional approach towards best practice in integrated service delivery for women undergoing internal radiotherapy. A consultant therapy radiographer at Cambridge University Hospitals NHS Foundation Trust is leading a collaborative project working with medical and surgical colleagues in the fields of oncology, gastroenterology, urology, pain management and palliative care. This team is designing a patient pathway and centralised approach to manage the multi-faceted complexities of long term complications and quality of life issues in the provision of oncology services for



this patient group. This work has arisen directly out of the lack of evidence base within radiotherapy about the effective treatment of pelvic tumours and the management of chronic toxicity post treatment. The latest evidence suggests services should be offering a joined up approach to deal with the physical and psychological impact of late side effects and this service illustrates the effectiveness of AHP clinical leadership for best service user outcome.

The benefits of improved integration can be demonstrated within the basic cancer pathway. There are aspects of cancer care that will always require centralisation and referral to highly specialist centres, for example the all improved outcomes that are seen when a patient receives their cancer surgery by a sub-speciality trained surgeon and their case managed by a specialist multi-disciplinary team. There will also always be a need for radiotherapy to be delivered within the centre. However, consideration should be given to the local provision of care; for example should/could a patient be offered chemotherapy at home or be provided information and choice regarding their treatment options in their own familiar surroundings, i.e. a community based AHP led service.

The advent of supplementary prescribing rights has allowed the redesign of podiatric services across both primary and secondary care setting in North Manchester. Delayed treatment of foot problems had previously meant longer lengths of hospital stay. With appropriate learning and development in supplementary prescribing, experienced podiatrists are working with an independent prescriber i.e. a doctor to implement patient specific clinical management

plans. The establishment of a community vascular triage clinic has enabled timely review of medication, sign posting to other community services and fast tracking to secondary services where appropriate. This triage service has effected an 80% reduction in referrals to secondary care, and the foot protection team a 60% reduction in patients needing to access emergency services. Implicit within these services is the public health, health of the public message on smoking cessation and exercise to support self care and improve clinical outcomes.

Choice and Personal Control

Key concepts:

- Patient choice
- Sharing the responsibility for current initiatives on helping people lead healthier lives
- Priority health and well-being issues and the role of AHPs
- Tackling waiting times
- Workforce planning – shape and skill mix

Choice and sharing responsibility

How a service user perceives his/her health need and its impact upon life is important to the overall perception of the quality of that life. Research indicates that the perception rated as most important for patients is the sense of mastery or control over their situation³. Being able to make choices about how and where help is sought is fundamental to ensuring that service users

³ Guyatt, GH, Berman, LB, Townsend, M, Pugsley, SO, Charles, LW (1987) A measure of quality of life for clinical trials in chronic lung disease. *Thorax* 42 773-778



have a positive experience of the health service. AHPs are well placed to work collaboratively with service users to enable them to make informed choices. By working closely with service users, AHPs act as key 'sign posters' for the appropriate patient journey as they are able to conceptualise for the patient the whole journey. Where needed AHPs can advocate for service users, bring a solution focus to individual patient need rather than clinical diagnosis, enabling patients to make informed choices and helping them to understand and balance the risks within the decision making process.

The following example illustrates how choice may be made available to patients in what has traditionally been seen as a clinical pathway with little choice. An AHP led specialist oncology service has successfully reduced in-patient stays for adjuvant brachytherapy treatments. Historically the procedure was undertaken by a clinical oncologist. The 10 hour treatment usually meant an overnight stay for the patient. Up-skilling of

the consultant radiographer enabled the consultant radiographer to undertake the complete treatment process, allowing a more convenient start time and the patient being discharged that evening. As a result of sharing skills, the patient is then afforded choice and could opt for a day treatment or an overnight stay with 94% (n=122) opting for day case treatment. This also resulted in increased efficiencies, reduced bed costs and improved continuity for the patient.

A physiotherapy led multi-disciplinary service set up in Hull and East Yorkshire Hospitals NHS Trust has significantly reduced readmission to hospital with respiratory infection in children with life limiting neurological conditions. Family members and carers of children with Duchenne Muscular Dystrophy underwent training in manual techniques and the effective use of cough assist devices to facilitate removal of lung secretions, thus avoiding repeated and prolonged hospital readmission. By working in partnership, sharing

responsibility and giving elements of control to the service user and carers, quality of life and the experience of living with illness has been improved. Success in achieving this service, as with others described above is underpinned by positive risk taking by AHPs in challenging current practice and offering a solution through service redesign.

Priority health & well-being issues and helping people lead healthier lives

Social inclusion is a fundamental tenet of well-being and AHPs have the skills and knowledge to engage and lead community group activities to promote inclusion. Dramatherapists acting in a socially deprived Fenland city in Cambridgeshire that has high unemployment, high crime and a low economy have successfully established a positive partnership between a voluntary sector organisation and a local housing association to provide community drama therapy for a group of 12-15 year olds. The impact of this work has been sustained and increased periods of concentration with positive links made to school experience and participation in after school activities. Although a long term projection, such benefits if sustained though service investment must impact positively on life achievement for the participants and therefore ultimately be of social and economic benefit to the community.

Waiting times

Effective clinical leadership from podiatrists in City & Hackney PCT has effectively reduced waiting times and increased access to services through a series of cost effective actions including: establishing a single

point of access for patients to book appointments by telephone and redesigning their workforce to address the need for biomechanics expertise. Concurrently the service identified a need for training in basic foot care for staff in residential homes. These simple changes have reduced waiting times by 52 weeks for new patients and by 78 weeks for those needing to see a biomechanical engineer. A further positive change for users in terms of their experiences of the service has been the 70% drop in complaints from patients in one year.

By offering increased flexibility in appointment times, direct access and self-referral, patient choice is further enhanced. For the working age population access to services outside working hours is recognised as improving sickness/absence figures and recovery rates. Patient choice is intimately linked with control and perceived quality of service provision. Establishing such service ethos requires appropriate skill mix and competencies across the appropriately structured workforce.

Shape of the workforce

AHPs recognise that the traditional ways of delivering services must change, that new roles must develop that have at their heart the delivery of first class patient focussed services. There are many examples where AHPs have extended their roles into areas more traditionally recognised as being held by medical practitioners. The establishment of numerous AHP consultant roles has promoted such innovations as the Birmingham East and North PCT physiotherapy triage team. This team has cut orthopaedic waiting times by reducing the number of patients referred for elective surgery by 70%. This service was set up 2 years ago and sees all patients that

local GPs consider are suitable for elective orthopaedic treatment. All patients are seen within 3 weeks and most are now managed in the community through a combination of physiotherapy, joint injections, education and support. While many of the patients will subsequently need surgery of some kind, they will only be referred to secondary care at the point of real need, when fit and ready for surgery. The impact of this service is to free up surgical time for cases of real need. The triage team are now working with other AHPs groups to provide a single point of entry for all those with musculoskeletal and rheumatology problems.

In Salford, redesign of the care pathway for overweight and obese people now means that dieticians work directly with PCTs advising on commissioning a whole obesity pathway based in primary care. The dieticians work with exercise specialists to deliver a care pathway that is removed from the traditional medical model of management for weight problems which data suggests was only effective in 30-50% of patients achieving significant weight loss and for many was not sustainable after the end of the programme. Sustainability is a core requirement for all service users engaged in life style management and change programmes. Achieving this via the traditional medical route using GP time is ineffective. AHPs because of their empowering relationship with service users are able to educate and support service users to sustain their new positive health behaviours much more effectively than the occasional check up visit to a GP.

Demographics indicate that the UK is becoming an increasingly old population, with concomitant increase in

the prevalence of long-term conditions. The development of health technologies, advent of tele-medicine and the e-health agenda will have a fundamental impact on service provision. AHPs are enabled to undertake innovative practice and role redesign because they are autonomous practitioners, most can act as a first diagnostic contact, they engage wholeheartedly in inter-professional working and have substantial clinical expertise. Currently there are issues about unemployment for AHP graduates, as there will be soon for new doctors. It is essential that workforce planning processes establish a structure for the workforce that has the potential to meet both current and future projected need. AHPs are unique in their ability to adapt and respond to change: they have an enormous contribution to make to the achievement of the ambitions for the NHS and partner services over the next 10 years, but this will be unsuccessful if the workforce infrastructures are not appropriately embedded now.

Workforce planning & development for AHPs

The NHS requires a flexible and competency based workforce planning – facts derived from the following documents and/or impact factors:

- Modernising Medical Careers
- Working Time Directive 2009
- Commissioning a Patient Led NHS
- Payment by Results
- demographics
- growing contribution of the independent and 'Third' sectors
- funding allocations to health and social care



Workforce planning needs to be more evidently and consistently linked with new models of care and with financial and service planning at all levels in the system, informed and developed with the input of the right people i.e. managers of services. If a new model of workforce planning is to be developed it needs to happen with the involvement of education and training providers. Commissioning of education and training needs to be strengthened and made more equitable so that training for all staff delivers the skills and competencies required to meet patient expectation at all levels (Our NHS, Our Future Interim Report 2007).

If the ambition is to deliver a clinical vision that is:

- needs/solution focussed
- service user centred
- less about therapeutic intervention and more about self-management, enabling continuation of social/

economic activity

- able to deliver quality clinical outcomes grounded in quality service user experience
- enabling and empowering service users
- focussed on capacity, health and maintenance of well-being and quality of life to reduce unplanned care
- overtly integrated between health, social care & education
- locally focussed, linking local services.

This will require a change in the future role of the clinician to be able to respond to the changing environment of service delivery i.e. primary care, community care closer to home and to employ a philosophy where there is plurality of provider.

It makes sense that within role redesign, less complex and commonly encountered service user requirements

⁴ Engeström 'The New Generation of Expertise: Seven Theses', in Rainbird, H, Fuller, A. and Munro, A. (eds) *Workplace Learning in Context*, London: Routledge (2004)

may be addressed by competent practitioners who are non-profession specific. The number of skilled AHP roles where specialisation is required that is case/patient pathway specific may need to increase. AHPs are well advanced in the notions of re-interpretation of expert practitioner away from the cognitive approach of development of individual expertise towards acceptance that the knowledge required to address complex problems associated with increasing co-morbidity cannot be contained by one individual but is situated within a community of practice. This is the underpinning philosophy of successful multi-disciplinary working and this community includes health, social care and education professionals and service users and carers. A new approach to expertise needs to focus on the capacity of working communities to cross boundaries⁴. Communities of practice should work together to solve complex problems (multi-professional service delivery). It is recognised that competency frameworks work less well for higher level deductive decision making in delivery for complex problems so a robust learning and development framework is required to support transition through the bands.

Any such workforce model should be service delivery focussed, link volume with capability, locally focussed with decisions about capacity made locally and factored into local service and workforce plans; and finally, is proactive. Potential development might be based on fully funded 7 day service provision where appropriate ensuring that any model integrates services to address service user need and maximises the usefulness of AHPs

in triage and first contact diagnostics to enable best use of GP or consultant time.

A suggested model is one

- based on population census data to determine demographic of SHA e.g.
 - population age profile
 - gender
 - lifestyle behaviours, obesity, smoking prevalence
 - employment characteristics of local area e.g. percentage of people or working age population with limiting long-term illness
 - general health profile data
 - aspects of social exclusion e.g. illness and age by accommodation type, economic activity and hours worked, general health and provision of unpaid care, households containing a person with a life limiting terminal illness, their age and number of carers
- collect epidemiological data on incidence/prevalence of condition e.g. stroke
- map epidemiological data against population statistics
- project likely incidence/prevalence data across population of SHA
- project percentage of low, middle, high impact event (based on incidence data for SHA)
- map low, middle, high impact event across patient pathway for each level
- project required workforce to deliver against identified projected need of service user group
- configured on known data and following an incremental and organised approach.

Conclusion

There is a clear need to identify the contribution of the AHPs and the financial rationale for the identified roles, linking clinical with cost effectiveness and quality of service. During 2005/06 NHS Employers' large-scale workforce change team ran a national workforce change programme to develop and implement new ways of working to improve services for people with long-term conditions⁵. Early results of this work indicated, inter alia, 69% of teams showed increased efficiency from integrated working, case management, redesigned care pathways and some variations in the long-term conditions workforce model. This is the context in which all AHPs are delivering services today.

AHPs are well placed to help shape these changes and to engage with new roles by understanding that such new roles do not mean loss of autonomy but a redefinition in redefined health and wellness service. AHPs also recognise that evolution of their professions is fundamental to delivering on Government drivers and that not only as individual professionals gain much more and are more effectively clinically, economically and qualitatively by sharing their knowledge and skills across professional boundaries, there is a positive impact on the quality of the user experience.

Allied



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