CENTRE FOR WORKFORCE INTELLIGENCE

ALLIED HEALTH PROFESSIONALS

WORKFORCE RISKS AND OPPORTUNITIES

A report to review the key workforce risks and opportunities within the Allied Health Professional (AHP) workforce.

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1 INTRODUCTION

The Workforce Risks and Opportunities project sets out the major risks and opportunities facing the health and social care workforce in 2011 and beyond. The purpose of this project is to provide an assessment of current workforce issues and potential opportunities for improvement. For each professional group within health and social care, existing analysis and data has been reviewed and updated. This grouping is based on the Department of Health Professional Advisory Boards (PABs). A suite of reports has been produced for each group outlining the main opportunities and risks facing the workforce.

The purpose of the Allied Health Professionals (AHPs) Workforce Risks and Opportunities report is to present the Centre for Workforce Intelligence's (CfWI) initial findings around key workforce risks and opportunities within the allied health professions to be reviewed with appropriate stakeholders. The paper considers the key workforce risks and opportunities within the allied health professions at a high level, identifying and assessing key issues and potential mitigation strategies throughout the allied health professions across all sectors. However, where the CfWI consider there to be a significant workforce issue, individual professional reviews have been included.

1.1 Data sources

Qualitative and quantitative data has been gathered from a number of sources in order to establish the workforce risk and opportunities within this report, including the review of key policy documents, papers and documents. Quantitative data has largely been gathered from the following sources:

- **Physiotherapy Workforce Survey (CSP, 2008):** The survey, produced with the assistance of the Association of Chartered Physiotherapists in Management (ACPM), was designed to provide the Chartered Society of Physiotherapy (CSP) with information on issues such as hard-to-fill posts, by both grade and clinical specialty. The results helped to produce evidence to the Pay Review Body, contributing to discussions on workforce planning, lobbying Government ministers, health departments and other stakeholders to ensure that physiotherapy services were given the resources needed to allow them to provide the best possible care to patients. The results of the survey were not published by the CSP; instead the data was used for analysis.

- **Speech and Language Therapy Recruitment and Retention Trends (Rossiter, 2008):** This survey was conducted by the RCSLT Membership and Communication Board Chair, Debby Rossiter. This was a final survey of

a series of six that started in 1997-1998, all of which reflected many of the themes and challenges facing the speech and language therapy (SLT) profession over the last 10 years. The results from this survey provided an accurate insight into the employment situation for SLTs and assistant practitioners in the UK. They also helped speech and language therapy in being recognised as a shortage profession and recognition that the future workforce would need to be increased.

- Evidence previously gathered by the NHS Workforce Review Team including workforce summaries, the annual Assessment of Workforce Priorities (AWP) (WRT, 2009) and National Shortage Occupation List Evidence Reports. (WRT, 2010).

2 OVERALL CONTEXT

When reviewing workforce risks and opportunities, it is important to consider the wider environment in which activity is taking place. The following section provides an overview of the external factors that may impact on workforce, in particular the current changes that are taking place within the system landscape.

Finance

The NHS is facing a period of sustained and significant financial constraint. Following the Comprehensive Spending Review (DH, 2010a) health spending is set to increase from £104 billion in 2010-11 to £114 billion in 2014-15, a total increase of 0.4 per cent in real terms, or an annual real terms increase over inflation of around 0.1 per cent. Since its inception, the NHS budget has grown by an average of over 4% each year in real terms. In order for the NHS to meet shifting demand resulting from demographic change and new treatments and technologies, significant savings will need to be achieved. To address these challenges, the DH is aiming to improve efficiency and productivity while maintaining quality of care and health outcomes through the Quality Innovation Productivity and Prevention (QIPP) agenda, setting a savings target of £20 billion by 2014. The report further states that these savings will be reinvested to support quality and outcomes. The CfWI is supporting strategic health authorities (SHAs) in developing and enhancing their workforce QIPP returns on a quarterly basis.

Workforce and productivity

Around 70 percent of NHS provider expenditure relates to staffing (House of Commons Health Select Committee, 2007). As NHS organisations seek to balance their budgets and achieve savings, future workforce activity should be fully considered to reduce the risk of incurring increased long-term costs. Large cuts to administrative and managerial staffing costs can make a modest contribution to savings, but the most significant savings can be achieved by increasing the productivity and efficiency of existing resources. For example, savings can be made by adjusting skill-mix. The healthcare workforce has historically been characterised by rigid role definitions across different professional groups and grades. *NHS Workforce Planning: Limitations and Possibilities* (King's Fund, 2010) recommends placing increased focus on further developing the skills of staff already involved in delivering services. It suggests that a more flexible approach can be more productive and improve the quality of services via role enhancement (a person taking on new skills), role substitution (working across professional divides), delegation (moving a task up or down grades with a profession) or innovation (creating new roles to fill competency gaps). Staffing resources can be allocated within service delivery as efficiently as possible, with care pathways designed to

avoid hospital admissions. Where clinically appropriate, care can also be brought closer to the community. Research suggests that there are potential productivity improvements of £4.5 billion from reducing variation in clinical practice in hospitals alone (King's Fund, 2010).

Liberating the NHS: Developing the Healthcare Workforce

Equity and excellence: Liberating the NHS (DH, 2010b) outlines radical plans to restructure the NHS. This was followed by proposals for planning and developing the NHS workforce, outlined in *Liberating the NHS: Developing the Healthcare Workforce* (DH, 2010c). In April 2011, the Government took the decision to "pause, listen, reflect on and improve our plans", and established an NHS Future Forum to listen to patients, professionals and members of the public and report.

In its response to the Forum's report on 'Developing the healthcare workforce' (DH, 2011a), the Government confirmed that it would:

- ensure a safe and robust transition for the education and training system, taking action to put Health Education England in place quickly to provide national leadership and strong accountability while moving towards provider-led networks in a phased way;
- ensure that, during the transition, deaneries will continue to oversee the training of junior doctors and dentists, and give them a clear home within the NHS family;
- improve the quality of management and leadership, for example by retaining the best talent from PCTs and SHAs and through the ongoing training and development of managers;
- further consider how best to ensure funding for education and training is protected and distributed fairly and transparently, and publish more detail in the autumn. (DH, 2011a)

Independent Review of Higher Education Funding and Student Finance in England, Securing a Sustainable Future for Higher Education in England (Browne, 2010)

The Browne report, published in October 2010, sets out changes on how higher education will be funded by students and the government. The full implications of the review on health and social care training will need careful consideration.

The Operating Framework for the NHS in England 2011/12

The NHS operating framework (DH, 2010d) sets out the national priorities for 2011/12, including maintaining tight financial control and performance on key

waiting times. The framework signals a move to measuring quality in terms of patient outcomes, such as reduction in emergency readmissions, and may therefore give greater visibility to the role of AHPs in the delivery of care. Changes need to be effected in order to meet the specific targets for individual healthcare groups outlined in the framework. While the operating framework makes no overt reference to specific Allied Health Professional (AHPs) staff groups, there are a number of national priorities and initiatives set out that will have direct impact on the AHP workforce. These include the following examples:

- The operating framework states that the NHS is expected to increase access to psychological therapies (IAPT) and continue expanding access to psychological therapy services in 2011/12 as part of the overall commitment to full roll-out by 2014/15. This will impact specific AHPs working in specialist mental health roles, including occupational therapists, physiotherapists, and speech and language therapists.

- The framework also suggests that PCTs should engage with local authorities and other partners to support and embed community physical activity initiatives for all ages alongside activity in schools in preparation for the 2012 Olympic Games. It states that GPs and other healthcare practitioners will be able to identify adults who do not currently meet recommended activity levels and support them in being more active through implementing the 'Let's Get Moving' physical activity pathway.

- The framework further highlights that the coverage of best practice tariffs, first introduced in 2010/11, will be expanded to cover a number of new service areas. It will mandate a national currency for cystic fibrosis services, which reflects the care that patients receive over the course of a year; develop a local currency for podiatry services, based on a simple treatment episode or package, and mandate the allocation of service users to mental health care clusters.

Rehabilitation and reablement are key focus areas, with new funding being made available. Reablement aims to maximise the recovery of older people, in particular, with the benefits of reducing the need for hospital admission and/or the need for ongoing social services support. As detailed in a joint letter dated January 2011 from the Director General for Social Care and Local Government and Care Partnerships within DH and the Deputy NHS Chief Executive (DH, 2011b) to all national health authorities, the £70 million extra funding would be allocated to Primary Care Trusts (PCTs) to be spent this financial year across the health and social care system to enable the NHS to support people back into their homes through reablement. Funding may be transferred to local partners or pooled budgets. The letter further states that PCTs should develop plans in conjunction with local health authority and foundation/NHS trusts and community health

services on the best way of using this money. How much of this money is spent on NHS services and how much on social care is to be decided locally.

Social care

The operating framework sets out the redistribution of funding allocations from health to social care, in line with the current government priority of strengthening social care services. The implications of this shift, as well as the personalisation agenda, should be considered as drivers of workforce change (DH, 2010d).

Management of risk

Reorganisation raises a number of challenges for successful workforce planning. There is a risk that the impending organisational changes of the next two years will distract from the QIPP agenda, as highlighted in a report by the King Fund (Kings Fund 2010). This risk will need careful management, if the NHS is to continue delivering high quality services. GP consortia and healthcare providers taking on functions from SHAs and PCTs should consider how to capture the knowledge and expertise of staff currently managing those functions. It is vital that security of workforce supply is maintained during the transitional period: PCTs and SHAs will be working with GP practices over the next two years to help prepare for the new arrangements. As the number of foundation trusts increases and commissioning is further decentralised, commissioners should carefully manage the risk of fragmentation of decision making and a potential lack of alignment of decisions on workforce supply (Kings Fund, 2010).

3 RESEARCH BY THE UNIVERSITY OF MANCHESTER

The University of Manchester is an academic partner of CfWI. In this capacity, it has drawn on research in a number of focus areas to support the WRO project and has produced papers to complement the WRO reports. These include two generic papers on the economic context and options for future ways of working. These background context papers will be of interest to a broad audience, including workforce planners. The papers can be accessed in full from the CfWI website at www.cfwi.org.uk.

1.1 Generic context papers

- **Recession, Recovery and the Changing Labour Market Context of the NHS (Rafferty, Rubery, Grimshaw, 2011)**

  This briefing synthesises findings on the changing labour market within the NHS and identifies the key implications for workforce planners and human resources. Focus areas include:

  - Increased unemployment and fewer opportunities in the wider labour market potentially alleviating shortages in NHS labour supply.
  - The development of strategies to attract EEA migrant labour.
  - Increased opportunities for women, partly as a result of past changes to the welfare and benefit system.

  The paper also highlights the need to continue to monitor the situation regarding:

    - the changing labour market
    - further welfare reform which may shift financial incentives
    - the impact of immigration policy developments on labour market needs by occupations, professional groups, service pathways and region.

- **Labour Substitution and Efficiency in Healthcare Delivery: General Principles and Key Messages (Sibbald, McBride, Birch, 2011)**

The substitution of one kind of worker with another is one strategy for improving the effectiveness and efficiency of health care provision. This briefing paper aims to inform managers and workforce planners about the likely consequences of such changes. It draws on economic principles and studies across a number of occupational work groups in the healthcare sector. Findings indicate that labour substitution:

- Is a plausible strategy for addressing workforce shortages
- Can reduce (wage) costs - under certain conditions which can be challenging to meet
- Can improve efficiency - under certain conditions which can be challenging to meet

The paper emphasises the need for healthcare planners and managers to give careful consideration to the economics of labour substitution, in order to ensure it does not lead to an increase in costs and reduced efficiency. It also describes other factors which affect the feasibility of labour substitution, including training and regulation requirements.

4 INTRODUCTION TO THE ALLIED HEALTH PROFESSIONS WORKFORCE

The Allied Health Professionals (AHPs) are a diverse group of statutory-registered practitioners who deliver high quality care to patients across a wide range of care pathways and in a variety of settings (DH 2009a).

AHPs must be registered with the Health Professions Council (HPC). The HPC is an independent, UK-wide regulatory body responsible for setting and maintaining standards of professional training, performance and conduct of the healthcare professions that it regulates. From July 2003, the HPC introduced 'protection of title' for the allied health professions (DH, 2009a).

AHPs are graduates[1] with specific and scientific training. They are highly skilled practitioners and have four common attributes:

1) They are mainly first-contact practitioners.

2) They perform essential diagnostic and therapeutic roles.

3) They work across a wide range of locations and sectors within acute, primary and community care.

4) They perform functions of assessment, diagnosis, treatment and discharge throughout the care pathway – from primary prevention through to specialist disease management and rehabilitation, often without the need for referral.

The knowledge, skills and experience of AHPs is often at the interface between healthcare sectors and settings. It can play a key role in driving up productivity in line with the Quality Innovation Productivity and Prevention (QIPP) agenda, reducing hospital admissions and length of stay. Furthermore, AHPs can be viewed as fundamental to delivering care closer to home, preventative care and the management of long-term condition (DH, 2009a).

The professions and their roles are as follows:

[1] * With the exception of Paramedics, who have moved to education at Dip. HE level in recent years.

Art therapists provide a psychotherapeutic intervention that enables clients to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.

Drama therapists encourage clients to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.

Music therapists facilitate interaction and development of insight into clients' behaviour and emotional difficulties through music.

Chiropodists / Podiatrists diagnose and treat abnormalities of the foot. They give professional advice on prevention of foot problems and on proper care of the foot.

Dietitians translate the science of nutrition into practical information about food. They work with people to promote nutritional wellbeing, prevent food related problems and treat disease.

Occupational therapists assess, rehabilitate and treat people using purposeful activity and occupation to prevent disability and promote health and independent function.

Orthoptists diagnose and treat eye movement disorders and defects of binocular vision.

Paramedics are pre-hospital health professionals who provide urgent and emergency care to patients. They assess and treat patients before transferring or referring them to other services, as appropriate.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity, supporting self-management, promoting independence and helping prevent episodes of ill health and disability developing into chronic conditions.

Prosthetists provide care and advice on rehabilitation for patients who have lost or who were born without a limb, fitting the best possible artificial replacement.

Orthotists design and fit orthoses (callipers, braces etc) which provide support to a part of a patient's body, to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing.

Diagnostic radiographers acquire and report on high-quality images, using ionising and non-ionising radiation and various forms of digital imaging systems.

Increasingly, image acquisition and reporting is integrated into patient care pathways and their management.

Therapeutic radiographers treat mainly cancer patients with ionising radiations which are delivered using highly complex technology to maximise tumour irradiation and minimise irradiation of normal tissues; they also sometimes use drugs in treatment regimes. They provide care across the entire cancer care pathway.

Speech and language therapists work with people who have communication and/or swallowing difficulties (DH, 2009a).

2 KEY WORKFORCE RISKS

The following section of this report identifies key workforce risks within the AHP workforce. These have been broadly segmented into two groups; workforce issues which are evident among several professions and significant workforce risks within individual professions, as illustrated in the table below.

Group	Risk	Page
All	There is evidence that a number of allied health professional groups will see a reduction in the number of commissioned university places.	15
	Clinical placement capacity limits the increase of education commissions.	16
	The current freezing and downgrading of posts in NHS services may cause staff to pursue careers in other sectors.	17
	A shortage of senior and specialist staff have been reported by a number of AHP groups.	17
	A number of AHPs are employed across multiple sectors including social care, voluntary sector, prisons services, and education. Further work is required to understand the workforce requirements of these sectors, particularly with the probable expansion of providers under the any qualified provider framework.	18
	There is a risk to AHP workforce supply due to overseas recruitment.	24
Chiropody and Podiatry	There is currently a lack of Band 5 posts available within the NHS.	17
Diagnostic radiographers	A number of policy initiatives such as the National Stroke Strategy and the development and extension of screening programmes will place increasing demands on diagnostic radiographers. This is especially true for sonographers.	21
Orthoptists	There is evidence that members of orthoptic teams are working additional paid and unpaid hours.	22
Paramedics	A possible move to a degree entry may pose a risk to the future workforce supply due to an increase in training attrition rates and the financial burden placed on students.	23

Prosthetists and orthotists	Contracts between NHS trusts and service providers do not provide for the supervision needs of new graduates or placements and trusts will typically not pay extra within the contracted price in order to support the training needs of newly qualified graduates.	24
Therapeutic radiographers	Increasing demands due to improving access to radiotherapy treatment coupled with high attrition rates for training places poses a significant risk.	24
Physiotherapists	A decreasing number of training places creates a risk that the number of physiotherapists available for employment within the NHS and beyond will begin to decrease within the next five years.	15

Table 1: Risk overview

2.1 Reduction in education commissioning

As highlighted in an article published on the CSP website the DH Workforce Availability Policy and Programme Implementation Group (WAPPIG) guidance paper (CSP, 2010a) by the non-medical workforce planning task and finish group to SHAs around education commissioning, the guidance paper has suggested a cut-back in training places to reflect a 14 per cent reduction in funding in order to meet the 'quality and productivity challenges that lie ahead'. This guidance paper also asked SHAs to consider future demand and local risks to service delivery when reviewing commissioning intentions, 'which might suggest that the pre-registration training of midwives, radiographers, and speech and language therapists will need to be maintained.'

There is evidence that some allied health professions will be impacted by this. For instance, intelligence gathered by the College of Occupational Therapists (COT), indicates that some universities faced five per cent commissioning reductions for the academic year of 2010/2011. It also indicated that many universities are expecting 10 per cent to 20 per cent commissioning reductions for the academic year 2011/2012 (CfWI, 2010a). Evidence provided by the CSP in 2010, highlighted a 30% decrease in commissioned training places for physiotherapy between 2005/06 and 2010/11(CSP, 2010b). Modelling undertaken by the CfWI confirms that, due to concerns about an oversupply of graduate physiotherapists, places on physiotherapy training courses were cut by 30% between 2005 and 2010. The report further states that if there is a decrease in the commissioning levels of physiotherapy training places, there is a risk that the number of physiotherapists available for employment within the NHS and beyond will begin to decrease within the next five years (CfWI, 2010b).

A parallel perspective is given in the Browne (2010) report, 'Securing a Sustainable Future for Higher Education'. In 2009, Lord John Browne led an independent panel to review the funding of higher education and make recommendations to ensure that teaching within Higher Education Institutions (HEIs) is sustainably financed. The Browne (2010) report proposes that the finance system is put on a more secure footing by seeking higher contributions from those that can afford to make them, and removing the blanket subsidy for all courses. However, this should be done without losing vital public investment in priority courses. These measures create the potential to allow the numbers of student places to increase by 10 per cent and enhance support for living costs while still allowing public spending reductions to be made.

The CfWI suggests that the potential impact that a reduction in education commissioning may have on the AHP and clinical academic workforce is further investigated and potential mitigation strategies presented for discussion.

2.2 Availability and quality of supervised clinical placements

Evidence gathered by the NHS WRT found that several allied health professions faced limitations on the growth of education commissions due to a limited number of clinical placements being available, as described below. For various allied health professions this creates a significant supply risk.

For example, there is a reported lack of clinical placements and supervisors available to students undertaking a BSc (Hons) in Podiatry. Currently, the chiropody/podiatry case load in the NHS tends to be made up of a majority of high risk patients with complex needs, making recent graduates unattractive to employers. This is because they do not have the experience to handle complex cases and require a reasonable amount of supervision, creating an additional effect of making it difficult for students to gain low level care experience (WRT 2008a).

The orthoptist workforce appears to be in a similar position. The growth of clinical placement capacity within the orthoptist workforce is limited as some trusts are reluctant to take students on placements. This is due to a lack of available funding to offset the reduction in patient throughput caused by training students (WRT, 2008b).

A similar situation is apparent within the prosthetist and orthotist workforce; however the situation is further compounded by the fact that many orthotists are independent contractors, who are not paid to work in supervisory roles for new staff. Trusts do have an option to pay extra for supervisory roles but are either not willing or able to do so (WRT, 2008c).

An expansion of providers through the "any qualified provider" framework has the potential to further exacerbate a shortage of clinical placements unless providers are compelled through contractual arrangements to share the costs of training future workforce.

In a report to the National AHP Advisory Board on the outcomes of the Modernising AHP Careers Programme (Selvadurai S et al, 2010), Work stream 3 considered how to better secure the quality of practice placements over a variety of care settings. The review found that in light of the good practice already in place, there was no case for mandating practice educator training nationally. However, practice educators teaching radiography, physiotherapy and occupational therapy can provide accreditation under schemes delivered and

promoted by their professional bodies. Universities have also started using Support for Learning in Practice (SLIP) Framework for occupational therapists and physiotherapists and Physiotherapy Placement Integrated Management System (PPIMS) is being used in nine universities.

To secure practice placements for AHPs outside of the hospital, two key success factors were identified: 1) as the funding of practice placements and 2) support of professional bodies. With regards to support from professional bodies, several have made explicit the duty of their members to develop the future professional workforce. Physiotherapy in particular has produced guidance for developing placements outside of the acute setting which emphasises gaining competencies in a specific setting rather than experience. The College of Occupational Therapists (COT) has also championed more innovative practice placements, particularly in private and voluntary organisations.

There are a number of examples of developing practice outside of the acute setting, such as within dietetic services, ensuring that students spend time in community aspects of their work. Furthermore, some universities are supporting research on placements in non-traditional settings, such as a project lead devoted to developing placements in palliative care, homeless hostels and charities such as MIND.

2.3 Current freezing and downgrading of posts

The current freezing and downgrading of some senior posts in some services is also of concern to various AHPs as this may cause staff to take up job opportunities in other sectors, resulting in a loss of skills and knowledge. This is highlighted in an article on the CSP website stating that trusts were downgrading posts to provide extra staff, such as splitting one Band 8 role into two Band 6 jobs. It was stated that physiotherapists would leave the NHS unless the situation was tackled. (CSP, 2011)This may be further compounded by the fact that allied health professionals are eligible to work in a wide range of sectors.

2.4 Shortage of senior and specialist staff

There is evidence that a number of the allied health professions have difficulty filling more senior posts and specialist posts. For example, a survey performed by the CSP (2008) covering 126 NHS trusts found that many respondents reported problems recruiting to various levels of senior posts. Similar findings were reported by Rossiter (2008) for senior speech and language positions, especially in adult learning difficulties. Research undertaken by the CfWI into the workforce implications of establishing Regional Trauma Networks (RTNs) identified that the demand from increased transfer activity and longer transfer times has the

potential to place increase pressure on front-line paramedical staff, and needs to be considered locally (CfWI, 2011).

According to Developing a Research Culture in the Allied Health Professions (DH, 2010e), there is currently low participation among AHPs undertaking research. This could lead to a lower interest in training in AHPs if there are fewer opportunities or less encouragement or management support to undertake research. This could potentially impact professional development.

The Modernising AHP Careers work and the competency-based career framework (DH, 2008a) that has been developed, aim to provide increased opportunities for continued professional development and the embedding of structured career pathways. This may enable the further development of existing staff to fill more senior or specialist roles. The career framework enables individuals to identify the components (functional areas) of a job and the level at which these need to be undertaken. There are nine levels at which each functional area can be performed from initial entry level jobs to consultant practitioners and more senior staff. This provides a common language and currency to support workforce planning and career development. Structured career pathways should be firmly embedded to allow increased opportunities for continued professional development (CPD). This should occur in conjunction with establishing recruitment and retention strategies for more experienced practitioners.

This is further emphasised in the report to the National AHP Advisory Board on the outcomes of the Modernising AHP Careers Programme (Selvadurai S et al, 2010), where it states "with the ambitions and priorities for the NHS laid out by the government, it is clear that the competence based approach is more crucial now than ever before and the system can take full advantage of what AHPs can and should be doing to drive up quality and improve productivity". A cost effective workforce, taking a competence-based approach, maximises the potential of the staff to deliver best care by making appropriate and effective use of all of their skills. AHPs were early adopters of the competence-based approach, recognising the value of developing flexibility in the workforce. The competence-based career framework was designed to support AHPs to maximise the contribution that they can make to transforming healthcare for the benefit of patients.

2.5 Demand from multiple sectors

Most allied health professions work across a variety of sectors.

A good example of this is occupational therapists (OTs) who, as a diverse workforce, work across a variety of sectors. These include the NHS, social care, voluntary sector, housing, prison services education, work and pensions and the private sector (e.g. insurance, private hospital and legal work) (WRT, 2008d).

This can also be seen within the Dietitian workforce. According to the British Dietetic Association (BDA, 2011), there are a number of freelance dietitians that regularly help schools and other institutions to meet nutritional standards as well as in the food industry, e.g. Tesco. They help with Nutrition marketing strategies, food and labelling regulations, research and public health policy.

A further example is in podiatry where, according to intelligence gathered by the WRT, approximately 50%of qualified podiatrists work in private practice (WRT 2008a).

The CSP estimates that around 25% of physiotherapists working in England do so exclusively in non-NHS providers. It is expected that this percentage will rise under the "any qualified provider" framework (CSP, 2010b).

Education training commissioning needs to take into account the fact that AHPs work across a variety of sectors. A greater understanding is needed of the sectors in which they work and the demand of these sectors for various AHPs. Research is also needed into the reasons why some AHPs choose to work outside the NHS, as this would help to inform education commissioning (CSP, 2010b).

2.6 Demand from other countries

Evidence previously gathered by the NHS WRT indicates that there is a risk to AHP workforce supply due to demand from other countries.

To provide a few examples, there is evidence within the Prosthetist and Orthotist workforce that some staff are leaving the profession to work overseas, in particular the USA (WRT, 2008c). Evidence provided by the COT indicates that there has been substantial activity amongst international recruiters for OTs during 2009/2010, typically from countries such as Australia, New Zealand, Canada and Singapore. Regular demand is also evident from overseas volunteer organisations. Furthermore, demand from new graduates for information on working overseas from the British Association of Occupational Therapists has increased recently. Similar issues have also been expressed with regards to radiographers (both diagnostic and therapeutic) with recent recruitment campaigns to fill vacancies in Australia and Hong Kong (CFWI, 2010a)

This is of potential concern as if an increasing number of AHPs take up posts overseas due to the opportunities available, this will reduce the pool of resource available in the NHS. It will result in a loss of skills and knowledge within the service. This is a switch from past trends involving significant numbers of dietitians from the Antipodes moving to work in England. As a result, consideration needs to be given to recruitment and retention strategies, and the demand from other countries needs to be considered within workforce planning (CfWI, 2010a).

Within the UK itself, the demand from England, Wales, Scotland, and Northern Ireland also needs to be considered. This is particularly the case for the chiropody and podiatry workforce. As a result, workforce planning should consider supply and demand across all four UK countries and not plan for England in isolation (CfWI, 2010c).

2.7 A review of profession specific workforce risks

The following section includes a review of profession specific workforce risks. Professions have only been included within this section where there is evidence of a substantial workforce risk.

Chiropody and Podiatry

According to evidence previously gathered by the NHS WRT, there is currently a lack of band 5 posts available within Chiropody and Podiatry. Some NHS employers feel that employing band 5 staff within Chiropody and Podiatry creates unnecessary additional costs as band 5 staff require supervision and are likely to progress to band 6 roles in a relatively short time period (WRT, 2008b).

This is reflected in [2] 'Allied Health Professionals Bulletin September 2009, where it states that funding will not be available to employ band 5 AHPs (DH, 2009b).

'Podiatry Now' (2008) provides evidence that some trainees in podiatry are given opportunities to enhance skills and do prescription only medicines (POMS). While some trainees have taken new knowledge and skills further within their practice, others may not have the same opportunity. These individuals are new graduates who are not empowered within their first posts to utilise their POMs accreditation from their pre-registration training.
The report also states that the sharing of skills between the more experienced practitioners and the new and enthusiastic graduates has to be the future. Preceptorships or post-qualifying apprenticeship roles in both the private and public sectors may form an essential part of the immediate professional future as the curricula continue to evolve.

Diagnostic Radiographers

[2] Preceptorship is considered as a transition phase for newly registered practitioners, from the moment of registration, practitioners are autonomous and accountable

A number of policy initiatives are leading to increased demands on diagnostic radiographers, such as radiography reporting, which was recently announced by the DH as part of the 2010 spending review. Radiography reporting encourages the NHS to train radiographers to report on more straightforward x-rays in line with best practice so that consultant radiologists are free to assess the more complex images, CT and MRI scans. It is estimated this creates a saving to the NHS of £7.9 million annually (SCOR, 2008). Other policy drivers include the National Stroke Strategy (DH, 2007a), abdominal aortic aneurysm screening and the Cancer Reform Strategy (DH, 2007b), as well as annual increases to imaging referrals. 'Choice of Diagnosis' starting in 2011 is also likely to impact on the diagnostics workforce, as diagnostic services will play a key role in providing increased care in the community.

Evidence previously gathered by the NHS WRT indicated that in some areas diagnostic targets were being achieved through the use of agency staff and significant overtime working. It is likely that, without initiatives to redesign service delivery and increase appropriate sections of the workforce, the use of agency staff and other short term solutions will continue (WRT, 2008e).

The Society and College of Radiographers' (2010) states that in the 2009 to2010 academic years, the attrition rate was 25.4 per cent reflecting concerns about staff retention issues within the workforce due to a lack of career development opportunities.

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. The underlying principle is to improve patient outcomes by identifying and treating patients at early stages of certain disease. Diagnostic radiographers are the main workforce involved in various screening programmes in England, including:

- breast screening: an approach to detecting breast cancer in the early stages – women between the ages of 50 and 70 are offered a mammogram; this is extended to women between the ages of 47 and 73
- fetal anomaly: a programme to identify birth defects, such as Down's syndrome and spina bifida, early in pregnancy – the screening programme offers pregnant women an ultrasound scan at 8 weeks and between 18 and 21 weeks of pregnancy
- abdominal aortic aneurysm: in 2008 a national screening programme for abdominal aortic aneurysm was announced – men aged 65 will be offered an ultrasound scan of the abdomen (SCOR, 2009a).

As screening programmes develop and expand, increased pressure will be applied to the AHP workforce, in particular radiographers. Sonographers, a subset of the diagnostic radiographer workforce, will be particularly impacted due to existing supply issues. Sonographers are an essential component of the foetal anomaly and

aortic aneurysm screening workforce. In addition, they carry out a large number of the ultrasound examinations undertaken in diagnostic imaging departments. This workload is set to grow as GPs are encouraged to refer earlier rather than later for gynaecological/abdominal ultrasound where cancer might be a possibility; this is in accordance with cancer policy to improve early detection of cancers and so improve survival rates (SCOR, 2009a).

In order to mitigate some of these workforce risks, the CfWI suggests that service redesign solutions need to be considered for the delivery of diagnostic services. An example of this can be seen by looking at the Society and College of Radiographers' (SCOR) 4 tier model, (DH, 2003) which has four aims:

- To define multidisciplinary teams not by profession, but by the skills and competencies that best deliver the patient or client's needs.
- To promote new roles, extended roles and advanced practice that will encourage lifelong learning.
- To widen the routes of access to clinical careers and improve recruitment and retention of the health professions.
- In the public interest, to maintain practice standards and develop the inherent potential of all clinical practitioners.

The four tiers are as follows:

- Assistant Practitioner
- Practitioner
- Advanced Practitioner
- Consultant Practitioner

Orthoptists

As highlighted in a CfWI summary report (CfWI, 2010d) there is evidence that most members of orthoptic teams' work additional paid and unpaid hours in order to effectively manage their workloads across both clinical and administrative duties. The Pay Review Body has commented that high vacancy rates account for the need for additional hours. However, data indicates that SHAs with high vacancy rates are not necessarily the regions where staff are working the greatest number of additional hours.

Overtime by managerial level orthoptists accounts for the majority of unpaid hours worked and senior clinicians and heads of service are under pressure to sustain heavy workloads without additional staff. As a result, such individuals spend an increasing amount of time on clinical functions, causing them to carry out elements of their managerial roles outside of their contracted hours.

Aside from the high level of pressure on the existing workforce, such working practices may also mask the true figure of additional staff requirements. This issue is further compounded by the fact that evidence suggests there is currently a shortfall in the number of students graduating from university in relation to the number of full-time equivalent (FTE) vacancies.

In order to mitigate such workforce issues, the skill mix solutions within the Modernising AHP Careers Programme (DH, 2008a) are strongly recommended. These include extending roles to allow lower banded staff to take on additional responsibilities to free up the time of more senior level orthoptists, together with innovative use of staff rotas.

The report provides two examples: Frimley Park Hospital gives an example of skill mix solutions used locally. The hospital had been unable to recruit to a Band 6 Orthoptist post. To resolve the issue, they changed the skill mix of the team and appointed two Band 2 and 3 Orthoptic Assistant posts.

Belfast Health and Social Care Trust provides another example. In this case, the Head of Orthoptics found that skill mix proved to work well in glaucoma management. Using a regionally agreed competency manual, orthoptists have trained Band 3 Orthoptic assistants to assess 83 per cent of visual fields.

Paramedics

The College of Paramedics is currently undertaking a process of updating its curriculum guidance, which is due for completion during 2011. The current view is that, following input from educationalists and major stakeholders, the college will recommend an extension to the current two year diploma-level programme to three years, either at Dip. HE or degree (BSc) level. As a consequence, it is likely during 2011 that the College of Paramedics will invite universities to re-visit current education programmes and adjust them accordingly. However, such changes typically take three to five years to formalise.

It is not yet known what effect the shift towards degree entry will have on training attrition rates. Financial pressures upon students are also of concern as paramedic students do not currently have access to an NHS bursary. Although some SHAs do provide financial support, this is not standard practice. However, despite potential workforce risks, it is important to note that the College of Paramedics is recommending these changes in order to provide a workforce that is appropriately skilled and fit for purpose, with minimal cost to NHS ambulance services. The CfWI recommends the implications of a shift towards degree entry for paramedics should be investigated further.

Prosthetists and Orthotists

The majority of prosthetists and orthotists are employed by companies contracted into the NHS. Contracts between NHS trusts and service providers do not provide for the supervision needs of new graduates or placements and trusts will typically not pay extra within the contracted price in order to support the training needs of newly qualified graduates. Instead, service providers tend to recruit experienced staff, to the detriment of graduates. This leads to the loss of newly qualified staff to other professions (WRT, 2008c).

The CfWI recommends that this issue should be further investigated and consideration be given to ensuring an appropriate number of clinical training placements are available.

Therapeutic Radiographers

In December 2007, the Cancer Reform Strategy pledged to expand the capacity and effectiveness of radiotherapy services. Within the strategy, a 31 day waiting time standard was introduced for subsequent radiotherapy treatment, to be implemented by December 2010. This will result in increased demand for specialist staff with skills in radiotherapy treatment planning (dosimetry), such as therapeutic radiographers (DH, 2007b).

However, current evidence shows that there is difficulty in filling existing training places in therapeutic radiography. In 2007 approximately 75 per cent of training places were filled and the available 2008 data suggests a similar ratio, which makes it difficult to increase the therapeutic radiography workforce. Furthermore, there is evidence that some courses have very high attrition rates (approximately 50 per cent) (WRT, 2008f).

The Department of Health has undertaken work to lower in-course attrition and increase capacity. Examples of this include investing £5,000,000 in facilities for virtual learning, attracting mature students through the creation of innovative training routes with the opportunity for enhanced support, and the development of existing practitioner staff. SHAs and Higher Education Institutions (HEIs) should also consider converting some undergraduate courses to graduate training schemes for therapeutic radiographers.

Concerns have also been expressed by radiotherapy departments that changes in immigration policy could impact negatively on overseas recruitment. This could particularly impact on Band 5 vacancies (SCOR, 2009b).

Physiotherapy

The falling number of physiotherapy training places, as much as 30% between 2005 and 2010, has the potential to affect the future physiotherapy workforce significantly. If the number of training places commissioned decreases by a further significant amount, CfWI supply forecasts suggest the NHS physiotherapy workforce will decline in numbers from 2012. If the current level of training places is maintained, demand and supply of physiotherapists are projected to remain broadly in balance. As such, the likely future demand for physiotherapy services needs to be strongly considered in commissioning (CfWI 2010b).

3 KEY WORKFORCE OPPORTUNITIES

The following section aims to highlight key workforce opportunities within the AHP workforce. Workforce opportunities can be broadly defined as innovative solutions for ensuring a high level of quality in the delivery of care, through ensuring the optimum use of the existing workforce.

3.1 The use of new and extended roles

A number of AHP workforce groups have taken on extended or new roles, as described below.

- The extended roles and responsibilities within prescribing have benefited the quality of service for patients, as detailed in the 'AHP, prescribing and medicines supply mechanisms scoping project' report, Department of Health (DH, 2009a) :

    - *Quality – Patient Safety*
      Greater access to prescribing and supply of medicines by AHPs has the potential to reduce treatment delays, improve the specificity and responsiveness of prescribing and thereby reduce patients' exposure to safety risks.

    - *Quality – Patient Experience*
      Extension of prescribing and medicines supply for certain AHP groups would improve the patient experience by allowing patients greater access, convenience and choice.

    - *Quality – Effectiveness*
      Providing an increased ability for AHPs to prescribe and supply medicines, would quickly allow existing care pathway flows to offer more effective care. It would also future-proof the NHS with a flexible frontline workforce that is capable of leading the development of innovative new care pathways for the benefit of patients.

      The 'AHP, prescribing and medicines supply mechanisms scoping project' report, Department of Health also provides the following examples:

- Dietitians use patient specific direction [3](PSD) or patient group direction [4](PGD) to supply a range of renal, obesity, pancreatic and diabetes drugs. Dietitians also play a key role in advising other professionals on appropriate prescription in relation to changing nutritional status in a wide variety of conditions, in acute and community settings.

- Speech and language therapists currently make use of PSD and PGD to supply and administer medicines and assist in a variety of procedures. They also play a key role in assessing and recommending to other prescribers the appropriate borderline substances, such as thickening feeds.

  The report also states that AHPs play a key role in contemporary clinical pathways and currently have access to a complex mix of prescribing and medicines supply mechanisms. To date, their use of these mechanisms has been safe and to the benefit of patients (DH, 2009a).

- Ambulance Today (2010) reported in December that the South Central Ambulance Service NHS Trust (SCAS) has been working with falls prevention teams since July 2010 and this has had a large impact on the number of people injured by falls. The benefits of this scheme, to both patients and ambulance demand, have been highlighted in a report published in 2008 by the Care Quality Commission (CQC). Every month SCAS attends to 2,300 patients aged 65 or over whom have fallen. Historically, patients who have fallen once are more likely to fall again, resulting in repeat 999 calls. This places significant demand on the ambulance service. Before the falls referral scheme was introduced, 1 per cent of 999 falls patients were referred to prevention teams. This number has now risen to 70 per cent. The CQC describe the falls referrals project as one of the 'successful initiatives' which have helped the service to employ ambulance crews more appropriately (CQC, 2008).

3 Patient has been assessed by the Dr / prescriber, the prescriber then instructs another healthcare professional in writing to supply or administer a medicine directly to a named patient or to several named patients

4 A written instruction for the sale, supply and / or administration of named medicines in an identified clinical situation, it applies to groups of patients who may not be individually identified before presenting for treatment.

- South East Coast Ambulance Service NHS Trust (SECAmb) has developed the critical care paramedics (CPP) role to improve the quality of pre-hospital care for seriously ill and injured patients. After undertaking accredited training development programmes, CPPs had enhanced patient assessment skills and greater confidence in managing difficult airways. It is envisaged that CCPs will play an important role in critical care transfers releasing ICU nurses and doctors.

  The Falls Accident Prevention team has also released a booklet entitled 'Don't Fall, Walk Tall', within the Lancashire PCT, providing advice and a risk register to increase people's knowledge about more hazardous areas within the home (Lancashire, 2010). North East Ambulance Service staff and Northumberland Care Trust have also reported similar findings from work with community rehabilitation teams resulting in 4,000 fewer falls which has reduced bed delays, trolley waits and saved the ambulance service money (DH, 2008b).

- Framing the contribution (DH, 2008b), provides further examples such as :

  - Radiographers in Taunton working within the voluntary sector. The role of Macmillan radiographer was set up so that radiographers with extended competencies could support people in the community undergoing radiotherapy at specialist oncology centres which in some cases were some distance away. They provide a link between specialist centres and community services such as social care and palliative care. Taking referrals for people with complex psychosocial needs, the radiographers have expert understanding of how radiation can treat cancer and of the side effects that may occur. They work with everyone that the patient may encounter, helping them to anticipate these issues and managing them in a manner that supports the patient and their family at this difficult time.

The development of extended roles and new roles could help to create a more flexible workforce, with individual professions being able to carry out a wider variety of tasks and contribute to a greater level within multi-disciplinary teams.

3.2 The use of assistant practitioner, support worker and advanced practitioner roles

Humphries (2006) states: 'Managers and therapists need to maximise the use of skills by using assistants and helpers and by deploying qualified therapists more flexibly'. More recently, the Economic Case for Advanced Practitioners in Allied Health Professions (DH, 2010f), states "advanced practice roles bring clear benefits for patients, health providers and individual AHPs". Despite the lack of quantifiable

evidence for costs and benefits, it is clear Advanced Practitioners (AdPs) are likely to contribute to creating a 'High Performing Medical Workplace', and there exists a strong sense of their economic value among academics, practitioners and commissioners. This report also states "AdPs will have competencies that overlap with other professions and grades and this gives rise to opportunities for substitution: that is, an AHP advanced practitioner carrying out a task which would otherwise be carried out by a doctor or clinician" (DH, 2010f).

In order to ensure good retention levels of assistant practitioners and support workers, the establishment of clear career progression pathways is key, as demonstrated in the Modernising AHP Careers framework. The Modernising AHP Careers Framework, Meeting the Challenge: a strategy for the Allied Health Professions, (Selvadurai S, et al 2010), highlights the need for support staff to have improved access to further training and development. This was reinforced in Improving Working Lives for the Allied Health Professions and Health Care Scientists, which stressed that career development, should also be available to people who do not already hold professional qualifications.

A report to the National AHP Advisory Board in 2010 on the outcomes of the Modernising AHP Careers Programme emphasises the commitment in the NHS constitution to staff that they should be able to progress and develop rewarding and worthwhile jobs. Developing as an AHP advanced practitioner is an example of how AHPs achieve this progression. In areas where advanced practitioners already exist, they are well received by their colleagues. However, AHP advanced practitioners do not exist in all services. Where such roles are not embedded in service design, an opportunity is missed to maximise the potential of highly skilled and trained individuals who can deliver quality and cost effective services to patients.

The report also states Skills for Health and the DH will be working to build on the existing AHP advanced practitioner career pathway on the Skills for Health website by developing a Non-Medical Consultant National Transferable Role. In the first instance, this will be developed for AHP Consultants.

3.3 Supporting the delivery of increasing care in the community

The allied health professions already work extensively in the community and through early intervention and rehabilitation, are well placed to facilitate providing increasing care in the community, as described below:

- **Occupational Therapists (OTs):** As a result of their ability to develop and implement care plans to help patients maintain an independent lifestyle, OTs play a significant role in the management of people with long term conditions, including older people in the community.

- **Physiotherapists:** The delivery of physiotherapy services is increasingly shifting from the acute sector to primary care settings in order to strengthen the provision of accessible, personalised care. In addition, physiotherapy is a strong enabler of self-care, which in turn reduces GP consultation times and hospital length of stay. Self management is also helping individuals take control of their treatment. The NHS has introduced a choice and personal control agenda and has been promoting self care through the NHS Self Care week in November 2010. NHS Westminster (2010) is also currently piloting a Personal Health Budgets programme providing users with choice and control over the service they require.

Further specific examples of AHP groups contributing to the Transforming Community Services (TCS) programme are provided below.

- **Speech and Language Therapists:** At Sandwell PCT, speech and language therapists redesigned their service to provide a rapid response speech and language therapy service in end of life care to avoid unnecessary admissions to secondary care. They implemented rapid response dysphagia assessments where patients at risk of aspiration will be assessed within four working hours, as well as extensive training to community staff to enable frontline dysphagia management 24 hours, seven days a week long term. As a result of avoiding hospital admissions, the risk of acquiring a hospital related infection is reduced. 480 urgent contacts have taken place with 80 episodes of care completed in the six months from April 2009 – August 2009.Following an urgent assessment 75 admissions have been avoided. There has also been a 47 per cent reduction in the number of ward referrals within Sandwell Hospital for dysphagia related end of life dementia and 42 patients with end of life dysphagia have been transferred to community service from secondary care for follow up and support. The average length of stay for each end of life admission is ten days at a cost of £300 per day. Avoiding 75 admissions so far this financial year has saved £225,000.

- **Dietitians:** As reported in the South West AHP News (2010a) Malnutrition is a common and expensive problem which costs the NHS an estimated £13 billion a year. In a case study, a specialist community dietician at NHS Somerset reported how one Somerset GP practice has addressed this particular problem. Despite being a multidisciplinary responsibility, identification and treatment of malnutrition in the community is poor. Frome Medical Practice spends over £100,000 per year prescribing oral nutritional supplements (ONS), but they are often used inappropriately. They commissioned a practised-based project, which aimed to develop a clinically effective care pathway for identification and treatment of malnutrition, including appropriate prescribing and monitoring of ONS. The

specialist community dietician and her colleagues carried out an audit of ONS prescribing practice and reviewed all adult patients who had been prescribed ONS in the previous 6 months. Over 80 primary care staff were educated on how to identify and treat malnutrition using MUST (Malnutrition Universal Screening Tool) as recommended by NICE (2006). Care pathways and management guidelines were also developed. Results of the audit showed that 90 per cent of patients had received no form of nutritional assessment before starting ONS. None of the patients had an approved criterion for prescription documented and 37 per cent of patients were advised by the dietitian to discontinue their ONS prescription. In total 46 new patients were referred to the dietitian, which were all appropriate, based on their MUST (malnutrition) risk score. Over 8 months, monthly costs were reduced by £2,500, which resulted in an estimated annual cost saving of £32,000. In addition, switching to a clinically appropriate and more cost effective first line choice of ONS is estimated to be saving approximately £18,000 a year. Overall, this project improved access and availability to a high quality dietetic service. The project resulted in a strategy for managing malnutrition and ongoing dietetic service provision.

- **Podiatrists:** As reported in the South West AHP News (2010b) The Torbay Care Trust (TCT) podiatry services team have undertaken several projects to raise productivity and increase quality for the population of Torbay and South Devon. A project was set up to explore new ways of working that would enable TCT to meet referral targets and clear waiting lists, as well as meet savings of £46,000. Capacity and demand analysis was undertaken at 16 locations, together with workforce plan and skill mix reviews, as well as a review of equipment. Training has been provided to improve the skills of the workforce and support workers used alongside podiatrists in several pilot sites to reduce treatment times.TCT staff alongside Devon PCT Podiatry staff have also received an award from Devon County Council adult and community services for partnership working. Devon PCT created service developments to reduce unnecessary referrals to orthopaedics, by ensuring patients with orthopaedic foot and ankle problems were triaged first by the podiatry department. This reduced waiting times for the patient as well as the length of the orthopaedic waiting list and created more effective liaison between team members. Referrals to orthopaedics for surgical invention reduced to 8 per cent and treatment by a podiatrist proved to be more cost effective than an orthopaedic surgeon, resulting in 90 per cent patient satisfaction within the service.

- **Stroke Rehabilitation:** A stroke rehabilitation unit was established in the community hospital in South Devon and a specialist team of stroke therapists based in the community. The stroke pathway (Selvadurai S et al,

2010) was redesigned by the AHPs to prompt earlier discharge from the District General Hospital (DGH) to the rehabilitation unit and then earlier discharge home with the community team. Outcomes included:

- Medical staff at the hospital freed up in order to provide a thrombolysis service.
- Increased medical capacity to provide a Transient Ischaemic Attack (TIA) clinic.
- 82 per cent of patients with stroke are now admitted to the stroke unit – prior to redesign this was 46 per cent.
- Patients referred to the TIA clinic are seen the next working day.
- Length of stay in the acute hospital reduced from 19 to 10 days.
- Total length of stay reduced from 26 days to 23.5 days.
- User satisfaction is high (Picker and Royal College of Physicians' (RCP) stroke user questionnaire).

- Self management within long term condition pathways (DH, 2008b), has been a focal point for an AHP led scheme in Bradford and has been effective for services users with multiple sclerosis. The scheme allows services to be designed around the patient to reflect their requirements. They also have access to a multi-disciplinary team when they feel their condition is changing so they can access the right service at the right time. The Bradford programme has shown that AHPs have the clinical and managerial capabilities to lead services allowing users to experience a coordinated approach to care from a team who share their knowledge.

- South West AHP News (2010c) also reports that the Torbay Hospital Physiotherapy Outpatient Team has undertaken an initiative to improve access and enhance patient care, which has also led to cost reductions. Waiting times in 2005 were beyond 12 weeks and Did Not Attend (DNA) rates of more than 20 per cent were a common problem for outpatient physiotherapy services. Previous methods such as waiting list management, blitz days, partial booking, and telephone triage had shown no long term effect in reducing DNAs and/or the waiting list. Attendance at a Choice Appointment workshop in Eastbourne to see how they had implemented this style of booking prompted a capacity and demand modelling exercise for the service in Torbay. Key stakeholders were invited to support the changes required to improve access to primary care physiotherapy. Initial results showed waiting lists were reduced by the use

of locums, and a new booking system was introduced. Patient referrals from GPs to physiotherapists were streamlined allowing patients to book by phone 48 hours later for a same day appointment. Self referral, advocated in 'Framing the Contribution of AHPs', (DH, 2008b) offered opportunities to further enhance the service. GP referrals were no longer accepted. Patients who attended their GP were handed a leaflet with the Physiotherapy phone number and posters were distributed to surgeries to advertise self referral. Even though eighty per cent of patients still choose to see their GP before referring themselves, comparative data from the first 2 quarters of 2005 and 2009 showed an improvement in DNA rates from 22 per cent to 2 per cent and waiting times from 12+ weeks to zero weeks. There was an increase in activity from 5885 to 6929 contacts and a reduction in the time taken to complete each patient episode from 150 minutes to 87 minutes per episode. The changes made are now embedded as standard practice and the service is more patient-centred. Improvements in productivity have been maintained with no additional cost to the Trust.

3.4 Public health and health promotion

Public Health is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. AHPs, with their holistic and person-centred approach to health and well-being, are well placed to lead the delivery of services requiring long-term support, regardless of setting, with improved continuity of care (What is Public Health, 2010).

Many of the public health initiatives have activity and exercise as the central focus. The Healthy Schools Programme (NHSP), launched in 1999, is a joint initiative between Department for Children, Schools and Families (DCSF) and DH, which promotes a whole school / whole child approach to health. Nationally there are 41 criteria, set within four main themes, which schools have to meet to achieve Healthy School status. These themes are as follows:

1. Personal Social and Health Education
2. Healthy Eating
3. Physical Activity
4. Emotional Health and Wellbeing

The four core themes relate to both the school curriculum and the emotional and physical learning environment in the school. Although each theme covers a different area, they are all delivered using the whole school approach so the basic requirements are the same.

The role of the Public Health Dietitian has evolved to work closely with the Healthy Schools Programme ensuring that health promoting work in schools is co-ordinated and complimentary. The 'Public Health Dietitian' report (East Berkshire 2003) published by East Berkshire NHS gives a brief summary of the work of the Public Health Dietitian and provides an overview of eight key programmes which have been delivered in East Berkshire between April 2002 and April 2003.

The eight programmes are:

1. Schools Nutrition Network
   In January 2003, the Schools Nutrition Network was established. This network was set up to provide a forum for health professionals and local authority workers to discuss their healthy eating work and plan future programmes.

2. School Meals
   The Public Health Dietitian sits on the menu planning groups with Local Authorities and catering contractors to develop the school lunch menus.

3. Smiling for Life
   This is a national programme aimed at improving the oral and nutritional health of 0-5 year old children. Designed by the Health Education Authority, the programme is run locally by the 'Smiling for Life Alliance'.

4. Keep on Smiling
   The Keep on Smiling Programme, launched in June 2001, is an extension of the Smiling for Life Programme set in Primary Schools.

5. Food Awareness Week
   This campaign is designed to educate children about the importance of eating at least five portions of fruit and vegetables a day and the concept of a balanced diet based on The Balance of Good Health.

6. Food Garden
   The intention of the project was to involve children in growing fruit and vegetables to foster a positive attitude towards these foods and thereby increase intakes.

7. Cook Projects
   The Public health Dietitian and local chef patron designed and delivered two cook projects as part of the Thames Valley University Summer Programme. The students learned knife skills, butchery, fish filleting and about healthy eating.

8. Water in Schools
   Thames Water assessed the quality of drinking water in the school and made recommendations on the positioning of the water dispensers. Educational resources were developed with the children to raise awareness of the importance of adequate hydration. These were used to educate staff, pupils and parents about the three key messages of the campaign.

In July 2010, the new Coalition Government confirmed that Healthy Schools will continue, recognising that Healthy Schools plays an important role in helping children and young people reach their full potential.

Further campaigns include Change4Life, which was launched in January 2009 as a new £75 million society-wide movement to help every family in England eat well, move more and live longer by changing behaviour. The plan establishes a new framework for the delivery of physical activity alongside sport for the period leading up to the London 2012 Olympic and Paralympic Games and beyond. It also sets out new ideas for local authorities and primary care trusts to help determine and respond to the needs of their local populations. This is done through providing and encouraging more physical activity, which will benefit individuals and communities, as well as having the potential to deliver overall cost savings.

The AHP Bulletin (DH, 2009c) shows evidence of AHPs playing a crucial role in turning the Change4Life message into action through the use of physiotherapists and dietitians:

'Physiotherapy is synonymous with health and exercise, so we're a key profession in getting the Change4Life message out.'

'Dietitians working on a one-to-one basis can use the Change4Life resources to tie in with other activities so that families are offered a better package of both food and activity advice. Other dietitians, such as those working with the Healthier Schools programme, can use the resources so that people understand it's all the same consistent message'.

The Be Active, Be Healthy campaign, launched in February 2009 as part of Change4Life, tackled obesity by helping people to eat well, move more and live longer. Around £4 million was made available for county sport partnerships. This brings together PCTs, councils and other grassroots providers to co-ordinate physical activities alongside sports. The campaign has been backed by the BDA and will be supported by the CSP's Move for Health campaign, which was launched in summer 2009 to teach parents and children about the health benefits of exercise.

Other health promotion initiatives include self referral, which has service benefits and may lead to an improved patient experience. As stated in the Self-referral

pilots to musculoskeletal physiotherapy and the implications for improving access to the AHP services report (DH, 2008c), self referral contributes towards prevention of illness, promotion of health and wellbeing and early intervention. Self referral supports self care / self management, particularly on long term conditions, by empowering patients to increase their involvement in managing their condition. Patients can access AHP services easily, receive advice and treatment and prevent an acute problem from becoming a long term condition.

The report shows results of analysis from pilot sites indicate that patient self referral to AHP services can improve the patient experience and make better use of resources. As a result, 91 per cent of GPs wanted the self-referral facility to continue. The primary reasons cited included savings in GP consultation and admin time, convenience to patients, encouraging patient autonomy, and positive impact on waiting times. GPs consistently reported that the main factors influencing use of private providers over NHS services were ease of access, waiting times and convenience of appointments. A majority of GPs (60 per cent) and physiotherapists (80 per cent) considered that the choice of access had improved as a consequence of introducing self referral. One less service specific benefit recognised at all of the pilot sites was the greater knowledge of population demographics gained through the pilot. This was particularly useful for the sites in considering how they made information on self referral available to groups that rarely give feedback within the pilot practice populations. These include Black Minority and Ethnic (BME), home carers and patients within mental health care.

Service Benefits:

- No increase in demand for services.
- Accessed by all demographics.
- Greater levels of attendance.
- No return to the NHS from patients traditionally seen within the private sector; associated with lower NHS costs (DH, 2008c).

3.5 Recovery, rehabilitation and reablement

There has recently been a focus within horizon scanning on rehabilitation and reablement, which has resulted in an extra £70 million of Government funding to the NHS for reablement. The position statement released by the BAOT and COT in 2010 (BAOT, 2010) states reablement is becoming a more commonly used term within adult social care services across the UK to describe services that maximise an older person's potential within the recovery process. Reablement either prevents the need for hospital admission or post-hospital transfer to long term care, or appropriately reduces the level of ongoing home care support required and the associated costs.

One of the professions that will be most significantly impacted by this funding will be OTs. Key benefits of reablement programmes delivered by OTs are:

- Re-integration of the service user into community settings that meet their desired goals for leisure and occupation (where measured this has reduced depression).
- Assisting individuals to return to work (either paid or unpaid) using a wide range of techniques, commonly known as vocational rehabilitation (where paid work has been achieved there have been added benefits of receiving a wage)(BAOT, 2010).

Campbell (2004) provides evidence of the efficacy of OTs within the context of reablement, "Occupational therapy-based rehabilitation offered in a one year period after stroke onset or discharge from hospital reduced the risk of patient deterioration in ability to perform activities of daily living for community dwelling patients".

The Investigating the Longer Term Impact of Home Care Reablement Services, Social Policy Research Unit (SPRU) (2009), states that councils with adult social care responsibilities are developing home care reablement services. The Care Services Efficiency Delivery (CSED) programme questionnaire distributed to councils in England during autumn CSED Reablement Questionnaire (CSED, 2006) found that 24 per cent already had a home care reablement service. It also found that 16 per cent had a limited service that they were planning to expand and 26 per cent were planning to establish home care reablement services CSED Reablement Services (CSED, 2007). An updated survey published in 2008 found that 106 councils had a reablement service in place, were seeking to expand an existing service or were in the process of establishing a service. About a third of councils supplying the necessary information reported that they charged for reablement services, while two-thirds did not and did not intend to CSED Reablement Services (CSED, 2008).

3.6 Supporting the Quality, Innovation, Productivity and Prevention (QIPP) agenda

AHPs are key players in delivering on the quality and productivity challenge. Examples of this include:

- The findings from the York Health Economics Forum, assisted by the British Healthcare Trades Association (BHTA), support previous reviews which attributed significant saving opportunities to Orthotic services. For example, a review of NHS Trusts has shown that for every £1 spent on orthotic intervention, the NHS saves £4 on care it would otherwise have to give. With spending on orthotics currently at an estimated £100 million a

year, this would represent a current saving of £400 million (BHTA Association, 2009).

- Improving the stroke pathway programme. The Stroke Reach early discharge scheme (REDS) team offers an early stroke discharge pathway for the residents of Camden and has been cited as an example of good practice (HSJ, 2010).

- Improved management of oral nutritional supplements can reduce inappropriate prescribing and slow the rate of growth of prescribing costs. In Warwickshire, three GP practices with the highest use of oral nutritional supplements audited patient records. Those where nutritional screening was used were reviewed by a dietitian to assess whether the prescription was appropriate. The findings resulted in potential savings of £200,000 per average PCT and significant improvements in clinical quality and outcomes. These included improved identification and treatment of malnutrition and therefore reduced risk of hospital admissions (DH, 2009a).

- Physiotherapy services are currently reconfiguring from five day working patterns to seven day patterns. A Quality and Productivity report published by Cardiff and Vale University Health Board (2010) shows that six extra physiotherapists were recruited to enable seven-day and evening physiotherapy for acute medical patients (medical admissions unit and emergency unit). Data was collected on physiotherapy response times, physiotherapy input, and patient length of stay. Initial results showed bed days were reduced by 1.5 per patient and the physiotherapy response times from referral to contact were significantly improved from an average of 13.7 hours to 2.3 hours. Other results included the development of a successful working staff rota, improved rapport with ward staff, improved links with community services and improved physiotherapy staff satisfaction due to improved patient care.

- The RCSLT has illustrated to the DH QIPP team that those patients with speech, language and communication problems can more effectively engage and access mainstream health services if they have access to specialist language and communication support. Specifically, the RCSLT reports that, through effective intervention, speech and language therapists will ensure mainstream services support the early identification of speech, language and communication difficulties. They will also ensure timely access to appropriate specialist services and organise the most appropriate programmes of care and work alongside others to ensure mainstream interventions are more effective for patients with speech and language needs.

Skills for Health has completed a suite of demonstrator projects showing how the AHP career framework can be used to improve productivity and service quality in different clinical and service settings. The three projects covered different themes and were undertaken with three different healthcare providers:

- Calderdale and Huddersfield NHS Foundation Trust used the framework to inform patient-centred service redesign and develop new roles in cancer and rehab services. Outcomes included a reduction in the length of hospital stays and readmissions (Smith R et al, 2009).

- Cheshire & Merseyside Critical Care Network used the framework to develop a competence based education and training framework for staff working in the critical care environment.

- NHS London used the framework alongside the Stroke Pathway to inform Advanced AHP practitioner development in all pathways and areas of practice.

4 SUMMARY

Key workforce risks within the AHP workforce are identified within this report. General workforce issues which are evident among several professions include potential reduction in education commissioning, availability of supervised clinical placements, current freezing of posts, shortage of senior and specialist staff, demand from multiple sectors, and demand from other countries. Where the CfWI considered there to be significant workforce issues, individual professional reviews have been included. These individual reviews cover the following professions: chiropody and podiatry, diagnostic radiographers, orthoptists, paramedics, prosthetists and orthotists, and therapeutic radiographers.

This report also highlights key workforce opportunities within the AHP workforce. These include the use of new and extended roles; the use of assistant practitioner, support worker and advanced practitioner roles; supporting the delivery of increasing care in the community; public health and health promotion; recovery, rehabilitation and reablement; and supporting the QIPP process.

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