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Allied Health Professionals: Their role in healthcare reform and developing primary and community care

This briefing paper aims to provide an introduction to the range of professions under the Allied Health Professions umbrella (AHPs); the direction for and input from AHPs envisaged in each of the key healthcare reform reports for NI over the past decade; summary of evidence brought by AHPs to the Health Committee's attention to date (previous and current mandate) and a range of other workforce evidence relating to AHPs, including good practice examples and recommendations and a discussion of the positives and challenges of wider use of AHP staff and the development of extended roles for such staff.

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Key Points

Allied Health Professionals (AHPs) are autonomous practitioners who assess, treat and discharge patients/clients. They are regulated by the *Health and Care Professions Council*.

The Public Health Agency lists seven main AHPs – dietitians, occupational therapists, speech and language therapists, orthoptists, physiotherapists, podiatrists and radiographers.

Art therapists, drama therapists, music therapists, orthotists, and prosthetists also fall under the heading of AHPs. In the rest of the UK paramedics are also recognised as AHPs, this is not yet the case in NI.

Over the past decade or so there have been a number of strategies aimed at reforming delivery and governance of health and care services in NI. This paper highlights the direction for and input from AHPs envisaged:

- Enhanced primary care services delivered by GPs with a special interest, nurses and AHPs;
- An integrated model of health and social care, with population-based planning of services and a clear role for AHPs positioned in the care model;
- The importance of GPs and other professionals working together as part of multi-disciplinary general practice teams;
- The recent Expert Panel and Department's report, *Health and Wellbeing 2026*, refer to the role that AHPs will play in the population health model and in the primary care based multidisciplinary teams.

The key issues for AHPs that a range of professional groups have highlighted to the Health Committee (past and present) in this regard include;

- The potential for AHP-led clinics – for example self-referral for muscular skeletal and back pain (pilot in South eastern HSC Trust currently being evaluated) and dietician-led clinics for nutrition-related conditions;
- Reablement of patients by AHPs - enabling people to return home from hospital and remain in their own home longer;
- The economics of using highly skilled AHPs to the full range of their skills;
- Seven-day working – AHPs are supportive with appropriate resources in place;
- The need for a repertoire of professions in primary care, including AHPs, and innovative ways of working to deal with the increasing numbers of patients with multimorbidities;
- Challenges for AHPs in influencing decision-making at senior level; and
- Paramedics - NI is the only jurisdiction in the UK where paramedics are not part of the AHP group of professions.

The approach being taken to developing primary care teams in England is highlighted in the paper, with particular reference to the work of Dudley Clinical Commissioning Group's 'Teams Without Walls', and the role for AHPs as recommended by the Primary Care Workforce Commission,

The paper reviews a range of good practice services and recommendations from across the UK by a range of AHPs focused on:

- Alleviating pressures in GP practices (for example self-referral to physiotherapy);
- Preventing unnecessary hospital admissions (for example a co-ordinated 'falls' service);
- Early interventions in community settings (for example prevention of malnutrition and speech and language therapy in schools); and
- Reablement of elderly patients to allow safer and quicker discharge of patients back home.

The paper also highlights the range of challenges to developing extended roles for staff, such as AHPs, as identified in a recent Nuffield Trust report.

1 Allied Health Professionals - Overview

Allied Health Professionals (AHPs) are defined by the Public Health Agency (PHA) for Northern Ireland (NI) as being a diverse group of clinicians who provide patient and client services through a range of pathways and settings:

Practical interventions from AHPs are often significant in enabling people to recover movement and mobility, overcome visual problems, improve nutritional status, develop communication and everyday living skills, thus allowing them to sustain and enjoy quality of life even when faced with life-limiting conditions.¹

The Department of Health (NI) lists '12 distinct and unique disciplines'² in the AHP Strategy for 2012-2017 - *Improving health and well-being through positive partnerships - A strategy for the allied health professionals in Northern Ireland.*³ The PHA lists seven main Allied Health Professions and describes the roles as follows⁴:

¹ Allied health Professionals, HSC PHA website available: <http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-6>

² <https://www.health-ni.gov.uk/publications/improving-health-and-well-being-through-positive-partnerships-strategy-allied-health>

³ Improving Health and Well-being Through Positive Partnerships (February 2012), Department of Health available: <https://www.health-ni.gov.uk/publications/improving-health-and-well-being-through-positive-partnerships-strategy-allied-health>

⁴ <http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-6>

- Dieticians - 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 (OTs) - assess, rehabilitate and treat people using purposeful activity and occupation to prevent disability and promote health and independent function;
- Orthoptists - Orthoptists diagnose and treat eye movement disorders and defects of binocular vision;
- Physiotherapists - assess and treat people with physical problems caused by accident, ageing, disease or disability, using physical approaches in the alleviation of all aspects of the person's condition;
- Podiatrists - diagnose and treat abnormalities of the foot. They give professional advice on prevention of foot problems and on proper care of the foot;
- Radiographers - Diagnostic radiographers produce high quality images on film and other recording media, using all kinds of radiations. Therapeutic radiographers treat mainly cancer patients, using ionising radiation and sometimes, drugs. They provide care across the entire spectrum of cancer services;
- Speech and Language Therapists (SLTs) - Speech and language therapists assess and treat people with communication and/or swallowing difficulties.

In NI, art therapists, drama therapists, music therapists, orthotists, and prosthetists also fall under the heading of AHPs. In the rest of the UK paramedics are also recognised as AHPs, this is not yet the case in NI.

AHPs are autonomous practitioners who assess, treat and discharge patients/clients. They are regulated by the *Health and Care Professions Council*⁵ (HCPC). The HCPC protects the public by maintaining a list of registered AHPs and ensuring they meet their standards of training, professional skill, behaviour and health. It currently regulates arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists /orthotists, radiographers, social workers in England⁶ and speech and language therapists.

All of these professions have at least one professional title that is protected by law.

⁵ HCPC, <http://www.hcpc-uk.co.uk/>, on 1 August 2012, the HPC took over the regulation of social workers in England and was renamed the Health and Care Professions Council (HCPC), reflecting its new responsibilities.

⁶ Social work regulation is a devolved matter in the UK, which means that there are three other social work regulators located in Northern Ireland, Scotland and Wales, A memorandum of understanding has been agreed between HCPC, the Care Council for Wales, the Northern Ireland Social Care Council and the Scottish Social Services Council (SSSC) (collectively 'the Four Councils') and this sets out a framework for the working relationship between the Four Councils in relation to the regulation of social workers and the approval of social work education across the UK.<http://www.hcpc-uk.org/aboutregistration/regulators/socialwork/>

This means, for example, that anyone using the titles 'physiotherapist' or 'dietitian' (whether working in public or private practice) must be registered with the HCPC. It is a criminal offence for someone to claim that they are registered when they are not, or to use a protected title that they are not entitled to use.⁷

Each AHP has its own professional body whose role is to advance the science and practice of the individual profession; promote training and education in the science and practice of the profession; and, in some instances, act as a trade union⁸.

2 Northern Ireland Health Reports – Direction for AHPs

Over the past decade or so there have been a number of health and care strategies and reports aimed at reforming delivery and governance of health and care services for NI. These were outlined in more detail in RaISe paper NIAR 149-16 (June 2016).⁹ The key policy direction has been the promotion of 'integrated working' between primary and community care, hospital specialists and social services. This section highlights the direction for and input from AHPs envisaged in each of the relevant strategies.

2.1 Caring for People Beyond Tomorrow (2005)

In 2005, the former Department of Health, Social Services and Public Safety (DHSSPS) published *Caring for People Beyond Tomorrow - a 20-year strategic framework for primary care*. It recognised the need for wider development of community-based alternatives to hospital admission but acknowledged that such an approach would make significant demands on community nursing services and rely on the skills of AHPs.¹⁰

The strategy proposed enhanced primary care services delivered by GPs with a special interest, nurses and AHPs, providing quicker access to a wider range of services close to home.¹¹ One of the key objectives (Objective 4) was to¹²:

develop and implement a range of primary care strategies for community care, community pharmacy, community nursing, child and family support, general medical services, general dental services, optometric services,

⁷ HCPC About Us, <http://www.hcpc-uk.org/aboutus/>

⁸ Public Health Agency, AHPs, <http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-6>

⁹ Thompson, Dr J. (2016), *Transforming Health and Social Care in Northern Ireland – Services and Governance*, NI Assembly, Research and Information Services, <http://www.niassembly.gov.uk/assembly-business/committees/health/research-papers-2016/>

¹⁰ Caring for People Beyond Tomorrow (2005), DHSSPS, section 2.11, <https://www.health-ni.gov.uk/topics/health-policy/primary-care-strategy#toc-0>

¹¹ As above, section 4.11

¹² As above, Objective 4, page 19

older people and carers services and services delivered by allied health professionals.

2.2 Transforming Your Care (2011)

The reform agenda gathered pace in June 2011, when the then Minister for HSSPS, Edwin Poots, announced a review of the provision of health and social care services. The Review, known as ‘Transforming Your Care’, (TYC) proposed an integrated model of health and social care, with population-based planning of services and a clear role for AHPs positioned in the care model in ‘local services’.¹³

The key drivers included - care to be provided as close to home as practical, a shift of resource from hospitals to enable investment in community health and social care services and a changing role for general practice working in 17 Integrated Care Partnerships (ICPs), building on the previous Primary Care Partnerships.

At that time 5% of HSC staff were classed as AHPs but it was acknowledged that the staff mix was primarily structured to support the existing institutionally-based care model.¹⁴ TYC proposed dedicated community-based clinics where patients can access¹⁵:

a range of health and social care services, including inputs from community pharmacy, Allied Health Professionals such as podiatry and physiotherapy, nursing care and social work support as well as from GPs with a Special Interest and hospital specialists.

The ICPs proposed under the new model, have a lead role in promoting health and wellbeing, including support for the role of AHPs in secondary prevention, particularly as regards older people, for example, the role of podiatry care in falls prevention, and occupational therapy in rehabilitation.¹⁶

The subsequent TYC consultation document *Vision to Action* highlighted investment in the capacity and capability of staff working across the HSC, for example GPs, nurses, AHPs and social workers, to ensure the “right people with the right skills are working in the right places”.¹⁷

In response to the TYC consultation respondents representing AHPs highlighted that they had much to contribute to the ICPs to better support the frail elderly and those with long term conditions. The College of Occupational Therapists stressed the vital role of

¹³ Transforming your Care – A Review of Health and Social Care in Northern Ireland, December 2011, page 6

<http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf>

¹⁴ As above, page 32

¹⁵ As above, page 45

¹⁶ Transforming your Care – A Review of Health and Social Care in Northern Ireland, December 2011, page 57

<http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf>

¹⁷ Transforming your Care, Vision to Action Consultation Document, page 59, <http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/TYC-Vision-to-Action-Consultation-Document.pdf>

Occupational Therapy (OT) in promoting independent living and requested that ICPs ensured that their profession was able to play a full part.¹⁸

As part of the implementation of TYC, each Local Commissioning Group (LCG) in NI produced a 'Population Plan' and the work of AHPs was specifically highlighted in a number of these:

- Belfast LCG – highlighted that AHPs were part of primary care services in Belfast as well as GPs, community pharmacists, community optometrists, general dental practitioners, community nursing and social work¹⁹.
- Northern LCG – noted the utilisation of a smaller number of strategically placed intermediate care bed based facilities (focus on rehabilitation and recovery) and with dedicated input from medical, nursing and other AHPs to enable people who no longer require acute medical input to have a short period of accommodation based 'Reablement'²⁰; and
- Western LCG – highlighted support for the health promotion and prevention role played by AHPs, particularly with older people²¹;

The TYC *Strategic Implementation Plan* highlighted that the 'Population Plans' focused primarily on the nature of the services changes and that the implications for the workforce would be developed with detailed discussions on nursing, midwifery, AHPs' and doctors' requirements to support TYC.²²

2.3 The Right Time, The Right Place (2014)

In 2014 the focus of reform moved to 'governance', when Professor Sir Liam Donaldson advised on governance arrangements across health and social care with ten recommendations in his report *The Right Time, The Right Place*. His report recognised that TYC contained good ideas for developing alternatives to hospital care and called for 'action not words' with a new costed, timetabled implementation plan and an impartial international panel of experts to review the configuration of HSC services.

¹⁸ Transforming Your Care, Vision to Action Post Consultation Report, March 2013, page 54,

<http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/03/Transforming-Your-Care-Vision-to-Action-Post-Consultation-Report.pdf>

¹⁹ Belfast Health and Social Care Trust/Local Commissioning Group Population Plan, <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care>, page 6

²⁰ Northern Health and Social Care Trust/Local Commissioning Group Population Plan, <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care>, page 28

²¹ Western Health and Social Care Trust/Local Commissioning Group Population Plan, <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care>, page 36

²² Transforming your Care, Strategic Implementation Plan, Final Version, October 2013, <http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf>

2.4 Review of GP-Led Primary Care Services (2015)

In October 2015, the then Health Minister established a Review of GP-Led Primary Care Services to make clear recommendations to address future demand for primary care medical services. The working group included - Deputy Chief Medical Officer; Chief Nursing Officer; Chief Pharmaceutical Officer; Head of General Medical Services; HSCB; representative/s from BMA NI GP Council, from RCGP, from the Royal College of Nursing, from Allied Health Professions Federation (AHPF) NI; HSC Trust Director of Primary and Community Care; and a patient/carer representative.

Vision for Primary Care²³ - The vision was the continued development of sustainable and accessible primary care services centred on the needs of patients - access to GP-led services within a reasonable timeframe and continuity of care provided where this is important to patient wellbeing. GP-led services to be integrated in partnership with other parts of the HSC system to develop and implement care pathways aimed at treating people in the most appropriate setting.

The Review noted that it will also be important for GPs and other professionals to continue to work together as part of highly skilled, multi-disciplinary general practice teams²⁴:

Continuing to build practice teams consisting of, for example, practice nurses, advanced nurse practitioners and AHPs will help to ensure that patients can be seen by appropriate professionals in a timely fashion and are supported to manage and improve their own health, that GPs have access to advice when they need it, and that GPs' time is reserved for patients who most need to see them.

2.5 The Expert Panel and 'Health and Wellbeing 2026' (2016)

In 2016, the then Health Minister, Simon Hamilton MLA, appointed an expert, clinically-led panel (somewhat based on the Donaldson recommendation) to consider, and lead debate on, the best configuration of services for NI. The panel, chaired by Raphael Bengoa²⁵, was a mix of local, national and international expertise and reported to the

²³ Review of GP-led primary care services in Northern Ireland - recommendations of working group - March 2016 (23rd March 2016), page 4, <https://www.health-ni.gov.uk/publications/review-gp-led-primary-care-services-northern-ireland-recommendations-working-group>

²⁴ As above, page 11

²⁵ Professor Rafael Bengoa practiced as a doctor for seven years in both hospital and primary care - key to his role in this panel - from 2009 to 2012 he was Minister for Health and Consumer Affairs in the Basque Government in Spain and during that time implemented a transformation of the region's health service during a period of severe austerity: *The former Basque Minister charged with sorting out our health service*, Scope NI, NICVA Newsletter, 8 January 2016, <http://scopeni.nicva.org/article/the-former-basque-minister-charged-with-sorting-out-our-health-service>

Health Minister on 21st July 2016. The Minister published the Expert Panel's report on 25th October 2016, alongside the Department's report *Health and Wellbeing 2026, Delivering Together*²⁶, which is the outworking of the Expert Panel's recommendations²⁷.

The Expert Panel and the Department's report refer to the key role that AHPs will play in the population health model (based around the framework of 'The Triple Aim', a local 'Accountable Care System' and risk stratification of the population in terms of health need). Particularly within primary care there is a need to move from the predominantly GP-led model of care to a more blended approach:

*...Our future model of primary care is to be based on multidisciplinary teams embedded around general practice. The teams will work together to keep people well by supporting self-management and independence, providing proactive management of high risk patients.... These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates.*²⁸

The report highlights that additional funding for primary care will be focused on developing these multidisciplinary teams, including funding to test the impact that specialist AHPs, such as physiotherapists, can have when working alongside the primary care team.²⁹

The Expert Panel's report highlights that the workforce approach needed to respond to a population health model is one where³⁰:

staff, professional and unregistered/unregulated, are recognised for the combined expertise they bring to a health and social care team that is built around the needs of patients. This will require a real shift from the current, sometimes narrow professional boundaries, to one that recognises that nurses, doctors, allied health professionals, and Health Care Assistants all have a role to play and one that focuses on having the right people in the right place at the right time to provide/contribute to the best care pathway for patients.

²⁶ Health and Wellbeing 2026, Delivering Together, Department of Health (NI) (25th October 2016), <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

²⁷ Systems, Not Structures: Changing Health and Social Care, Expert Panel Report, 25th October 2016, <https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report>

²⁸ Health and Wellbeing 2026, Delivering Together, Department of Health (NI) (25th October 2016), page 14, <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

²⁹ As above, page 15

³⁰ Systems, Not Structures: Changing Health and Social Care, Expert Panel Report, 25th October 2016, page 23, <https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report>

In the Minister' evidence to the Health Committee on 27th October 2016, Michelle O'Neill highlighted the key role that AHPs would play in the future and stated that she will³¹:

...meet AHP representatives, and I have engaged with some of them over the last five months. To put it simply, they are a vital cog in the wheel when it comes to multidisciplinary teams and how we will invest in primary care. Quite often, AHPs can provide services at primary care level that obviously mean that people do not need to be referred to hospitals.... In future, AHPs will have a key role to play in the multidisciplinary teams that I am talking about. I want them to know that I value what they do and that they will be a key part of the multidisciplinary teams in future...

3 Committee for Health, Social Services and Public Safety (2015) - Workforce Planning Review and Other Workforce Evidence

3.1 Workforce Planning Review – Health Committee (NI Assembly) and other Committee Evidence

During the 2011-16 mandate monitoring the implementation of TYC was key for the then Committee for HSSPS. Of particular relevance here is the Committee's Workforce Planning Review³² (September 2015). A number of overall key staff issues emerged including:

- New service models - The Committee concluded that there was a lack of clarity as to who was responsible for developing new service models under TYC; and
- Regional workforce planning - The Committee was concerned about the time that had been taken to produce the Regional Workforce Planning Framework. Its recommendations included that;
 - the Regional Workforce Planning Group should take a wider approach to workforce planning, making 'strenuous efforts' to avoid 'silo-based' approaches and focused instead on patient need; and

³¹ Transformation of Health and Social Care: Mrs Michelle O'Neill MLA (Minister of Health), 27th October 2016, Committee for Health, Official Report (Hansard), page 9, <http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx>

³² Review of Workforce Planning in the Context of Transforming Your Care, Committee for Health, Social Services and Public Safety, <http://www.niassembly.gov.uk/assembly-business/committees/archive/health-social-services-and-public-safety/reports/>

- The Department should consider how primary care services can be reconfigured regarding staff to deal with the increasing demands for GP appointments.

The Allied Health Professions Federation (AHPF) provided key evidence regarding the contribution that AHPs aimed to play in the delivery of the reform agenda for the HSC. AHPF is a UK-wide organisation and has management boards in England, Scotland and NI³³. The AHPF submission focused on four key themes which they considered support the case for including AHPs to transform delivery of care³⁴:

- AHP-led clinics - saving GP time by signposting patients to AHPs, self-referral for muscular skeletal and back pain (20-30% of GP appointments are for musculoskeletal (MSK) problems);
- AHPs enabling people to remain in their own home longer (for example - OTs providing aids and adaptations thus avoiding hospital admissions for falls, and improved management of pneumonia by AHP/SLT assessment of swallowing);
- Economics - AHPs are trained to degree level, with a postgraduate structure that allows specialism, with skills already available in managing - dysphagia (swallowing difficulties), diabetes, podiatric surgery, medical prescribing, back care);
- Skills - an integrated workforce planning mechanism - to ensure that the skills of AHPs are utilised appropriately.

Further evidence highlighted by the AHPF included³⁵:

- Challenges in influence - acknowledgement that AHPs find it difficult to influence in practical terms and also difficult to influence at senior decision-making level:

there is only one AHP adviser for 13 professions — well, it is 12 at the moment.... For those 12 professions, for one person to be seeking to advise on that number of professions is very difficult....So, even in the trusts, there is no model whereby AHPs, strategically, are positioned sufficiently to allow the agents of change, in band 5, 6 and 7 posts, to make a change. we are not consistently sitting round the table.

- Paramedics - reference in TYC to the NI Ambulance Service but rarely the paramedics themselves – NI is the only country in the UK where paramedics are not recognised as AHPs:

³³ Allied Health Professions Federation, <http://www.ahpf.org.uk/>

³⁴ Allied Health Professions for NI, Briefing Paper – Workforce Planning in the context of TYC, May 2015, provided to Committee for HSSPS, Workforce Planning Review 2015

³⁵ Review of Workforce Planning in the Context of TYC: Allied Health Professionals Federation NI, NI Assembly, Committee for HSPSSP, 27 May 2015, NIA 268/11-16, pages 143-155, <http://www.niassembly.gov.uk/assembly-business/committees/archive/health-social-services-and-public-safety/reports/>

We are pushing that forward locally with the Department...there are so many things that we can do that we are not being allowed to do within our local scope of practice; for example, advanced care paramedics and community paramedics running minor injury units and going out to people's houses and doing a minor assessment or a wound closure that would avoid an elderly person having to go to hospital....There has been some investment locally, and we are changing....we have started to assess, treat and sometimes discharge at the home or at the scene.... There are different referral pathways for different categories of patients such as diabetics and falls patients...It is very much trust-dependent....whether they can accommodate our referral to an occupational therapist or physiotherapist etc.

- Self-referral to physiotherapists – pilots only began in NI in the South Eastern HSC Trust in 2015 – in Scotland 86% of the population have access to full self-referral, 63% in Wales, England 40%;
- Other pilots – there are pockets of pilots across NI, for example:

Antrim Area Hospital....physiotherapists are going in to ED at the weekend to support people with soft tissue injuries by advising them appropriately. This means that the person not only gets the best physiotherapy assessment in ED but also gets appropriate management, so that it does not become a chronic problem;

- Seven-day working – AHPs have expressed support for seven-day working with appropriate resources in place, for example, SLTs assessing swallowing in acute hospitals may mean the difference between someone being able to leave hospital or not, assisting with patient throughput. Paramedics are a clear example of 24/7 working. There have been pilot schemes with OTs and physiotherapists working for seven days, these went:

surprisingly well. With appropriate resource, it prevents that massive block on a Monday and the massive rush on a Friday. You are also able to provide the right support in a timely way, which is very helpful not only to families but to patients.

Since the start of September 2016, the Health Committee has been briefed by a number of groups who have highlighted the impact that AHPs could have in healthcare delivery, as follows:

- The Irish Association of Trade Unions highlighted that AHPs³⁶:

can really come into their own... In Northern Ireland, we are only just at the stage of piloting self-referral for physiotherapy in the South Eastern Trust,

³⁶ Committee for Health, Official Report (Hansard), Briefing by Irish Association of Trade Unions, 6th October 2016, page 7, <http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx>

and it was a battle to get that pilot running. The frustration for us was saying, "Why do we need a pilot? We know it works". Roughly a third of GP consultations are musculoskeletal (MSK) conditions. Why are people going to their GP when they could go straight to the people who can treat them and start to deal with it efficiently? We still do not have the roll-out of self-referral across Northern Ireland....Northern Ireland is the only part of the UK that does not have podiatric surgery. That could reduce some of the work for orthopaedic consultants.

- The Royal College of General Practitioners (RCGPs) highlighted that general practice in NI is in crisis with, GPs not having sufficient time to focus on patient care, the role of GPs changing to deal with patients with multiple complex conditions and increasing GP consultations (over past 10 years increased by 60%). The RCGPs expressed the need to look at new innovative ways of working to transform how patient care is delivered, including³⁷:
 - The use of advanced nurse practitioners, pharmacists and physiotherapists;
 - New ways of referral; and
 - Direct access to physiotherapy for acute back problems.;
- The British Medical Association noted the need for a 'repertoire' of staff in a primary care practices, such as a mental health worker, a pharmacist, a physiotherapist and nursing staff that could take significant pressure off GPs and allow them to see more complex cases we need to see³⁸:

We should work over five years, bringing in, in the first instance, the pharmacists, the physios and the mental-health workers to gradually build up the multidisciplinary team.

The Royal College of Speech and Language Therapists have proposed that contracts with independent GP practices should provide clear incentives for developing direct access to multi-disciplinary services. It is suggested that the present financial payments for condition management such as respiratory, diabetes, hypertension and asthma could be realigned to redirect patients to AHP services; for example dietetics, speech and language therapy and physiotherapy.³⁹

³⁷ Committee for Health, Official Report (Hansard), Briefing by Royal College of General Practitioners, 13th October 2016, pages 4, 19, <http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx>

³⁸ Committee for Health, Official Report (Hansard), Briefing by the British Medical Association, 20th October 2016, pages 3, 14, <http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx>

³⁹ Briefing for the NI Assembly Health Committee review of the impact of the allied health professions to community care, 24/11/16, provided by email to Dr Janice Thompson, RalSe, NI Assembly by Alison McCullough, Head of the NI Office, Royal College of Speech and Language Therapists.

3.2 Approaches from England

3.2.1 Primary Care Workforce Commission

Health Education England (HEE) commissioned the Primary Care Workforce Commission to identify models to meet the needs of the future NHS. The resulting report, *The Future of Primary Care – Creating Teams for Tomorrow* (July 2015) highlighted a vision of primary care to include a wider range of disciplines including GPs, nurses and administrative support with teams including healthcare assistants, physician associates, paramedics, AHPs, social workers and others.⁴⁰

The key recommendation with regard to AHPs was that - more evaluation is needed of alternative approaches to using AHPs in primary care, especially to determine whether direct access for some conditions makes cost-effective use of NHS resources.⁴¹

The Commission received evidence on the roles that physiotherapists could take as part of primary care teams (face-to-face or phone triage of musculoskeletal problems, self-referral to physiotherapy, and physiotherapy as part of a falls service). In some areas of England, people may book directly with a physiotherapist without referral from a GP, though access may be restricted to those who meet pre-agreed criteria.

The report highlighted that published evidence suggests that the costs of self-referred physiotherapy consultations may be less than for patients referred by GPs, but that studies have not generally looked at the overall impact on general practice workload⁴²:

The economic benefit of physiotherapy interventions is likely to be greater if reduced time off work is taken into account – that is, increases in work productivity may offset possible increases in NHS costs associated with wider use of physiotherapists.

The report also highlighted that input from physiotherapy and other AHPs may be beneficial in maintaining independence for individuals with some long-term (for example, neurological) conditions and that physiotherapists' ability to work independently in primary care would be enhanced if they were more widely able to prescribe (since 2014, some have become prescribing physiotherapists). Overall⁴³:

The cost-effectiveness of individual physiotherapy interventions is therefore likely to depend on whether they substitute for, or are additional to, standard GP care and whether the economic benefits of returning to work are taken into account.

⁴⁰ The Future of Primary Care – Creating Teams for Tomorrow (July 2015), Report by the Primary Care Commission, page 12, <https://www.hee.nhs.uk/our-work/hospitals-primary-community-care/primary-community-care/primary-care-workforce-commission>

⁴¹ As above, page 24

⁴² As above, page 23

⁴³ As above, page 23

3.2.2 Good Practice Model of Integrated Care – Dudley Clinical Commissioning Group (Teams Without Walls)

Dudley Clinical Commissioning Group (CCG) (England) have been working over the past few years to put together a new model of integrated working across the five localities that make up the CCG. The multidisciplinary team (MDT) model is called 'Teams Without Walls' aimed at reducing inappropriate admissions to hospital and care homes and as an enabler for healthcare staff to deliver better care.

Dudley CCG was selected by NHS England, along with 28 other areas to take a national lead on transforming care for patients. Drawing on a new £200 million transformation fund and tailored national support, from April 2015 the 'vanguards' will develop local health and care services to keep people well, and bring home care, mental health and community nursing, GP services and hospitals together in England.⁴⁴

This new model will see teams working "without walls", taking shared responsibility for delivering shared outcomes centred around the person. Each MDT working at a level of 60,000 people, reaching a total population of around 318,000 across Dudley with all five teams. Each MDT has a lead GP and operates across a number of GP practices, the largest being a group of 11 practices. The GP takes overall responsibility for the MDT and the care of patients, there is shared responsibility for care across the team and complex cases with multiple comorbidities are discussed at MDT meetings. The teams include⁴⁵:

- GPs;
- District nurse team;
- Virtual ward team;
- AHPs
- Social worker;
- Mental health link worker;
- Community/voluntary sector link worker; and
- Community Pharmacist.

The CCG highlight that this approach is particularly useful for the 2% of their patient population who are most at risk of admission to hospital. These patients were identified through a risk stratification model. The community/voluntary sector link worker focuses on the social aspects to improve patients' health through tackling social isolation providing routes to social groups, education opportunities and other forms of support.

⁴⁴ Dudley to lead NHS into new era of patient care, NHS Dudley CCG News, <http://www.dudleyccg.nhs.uk/dudley-to-lead-nhs-into-new-era-of-patient-care/>

⁴⁵ RaiSe direct email contact with Clare Hamilton, Dudley CCG, 18th November 2016

3.3 Nuffield Trust – Reshaping the Workforce (NHS)

The Nuffield Trust was commissioned by NHS Employers to examine how best staffing can be re-organised to support new ways of delivering care. The report found that equipping the *existing non-medical* workforce (nursing, community and support staff) with additional skills is the best way to develop the capacity of the workforce.⁴⁶

The report highlighted one study estimating that up to 70 per cent of primary care physicians' work could be taken on by other health care professionals such as nurses or AHPs, and another systematic review has found that direct access to physiotherapists leads to improved patient outcomes and decreased costs⁴⁷:

Published evidence shows that trained physiotherapists are as competent at assessing orthopaedic outpatients as post-fellowship junior orthopaedic surgeons and consultations with physiotherapists have been found to generate lower hospital costs due to fewer X-ray or surgery referrals....Radiographers can successfully diagnose from x-rays...and the complication rate for radiographers performing barium enemas is similar to that for radiologists. Evidence from our case studies suggests that paramedic practitioners transport fewer patients to hospital while the introduction of the holistic worker is predicted to reduce the number of visits by community workers.

The report also focused on the challenges of developing extended roles for staff, including AHPs⁴⁸:

- It takes time and money to develop new extended roles;
- Staff working in extended roles may take longer to complete tasks, spend more time with patients, recall them at higher rates and carry out more investigations - hence, extended roles may not always be cost-saving;
- Evidence from the literature also suggests that delegation from GPs to others will only reduce the GP workload if they cease performing the delegated tasks;
- Staff working in extended roles might simply duplicate the work of others;
- Resistance from other professionals or patients - with time and education, patients will accept new and extended roles– something demonstrated in case studies of pharmacy and paramedic practitioners in primary care;
- An unwillingness of staff to work outside professional boundaries for a variety of reasons – for example, concern about having to take on more work and worries about professional liability;

⁴⁶ Imison C. et.al. (2016), Reshaping the Workforce to Deliver the Care Patients Need, Nuffield Trust in association with NHS employers, <http://www.nuffieldtrust.org.uk/publications/reshaping-the-workforce>

⁴⁷ As above, page 34

⁴⁸ As above, pages 35-36

- Senior clinicians or managers may also be resistant to change, and this can affect organisation-wide change;
- Lack of a clear regulatory framework - extended roles may not be formally recognised by professional regulators; and
- Commercial insurance companies may be required for staff working in extended roles in GP practices - cover can be very high for new or extended roles.

4. AHP Strategy (NI) 2012-2017

Improving Health and Well-being Through Positive Partnerships: A Strategy for the Allied Health Professionals in Northern Ireland ('the strategy') is the five-year strategy setting out a high-level road map for the entire AHP workforce and to support the commissioning and delivery of AHP practices. It covers the 12 professions listed in Section 1.

The exemplars in the strategy show how AHPs have met and plan to meet the key health reform objectives of prevention, early intervention (easing pressure in primary care) and helping to avoid hospital attendance and admission.⁴⁹ The strategy highlights the increased demand for the skills and expertise that AHPs contribute, where they are:

...an integral part of an increasingly corporate approach to the planning and delivery of health and social care, often working as leaders or members of multi-disciplinary teams with other professionals to provide high quality, integrated services within the primary, community and secondary care sectors.

The strategy is based around four strategic themes:

1. Promoting person-centred practice and care;
2. Delivering safe and effective practice and care;
3. Maximizing resources for success; and
4. Supporting and developing the AHP workforce.

The outcomes envisaged include *"...developing more effective partnerships and team working across organisational and professional boundaries, as a means of increasing the effectiveness of these services"*.⁵⁰

These themes are described further below with selected good practice examples relating to primary and community care.

⁴⁹ A Strategy for the Allied Health Professions in Northern Ireland 2012-2017, Department of Health, Social Services and Public Safety, page 14, <https://www.health-ni.gov.uk/publications/improving-health-and-well-being-through-positive-partnerships-strategy-allied-health>

⁵⁰ <https://www.health-ni.gov.uk/topics/health-policy/primary-care-strategy#toc-1>

4.1 Person-centred care

This focuses on four main areas:

- Ensuring personal and public involvement;
- Improving the service user experience;
- Promoting and supporting self-management; and
- Working in partnership.

A good practice example from community care was highlighted:⁵¹

Speech and Language Therapy - A nationally recognised partnership model between health and education for Primary 1 children in the Colinglen area of Belfast has resulted in 59% of those accessing the service being discharged with age appropriate speech and language skills:

- Improved early identification of children with speech, language and communication difficulties;
- Increased access to services with a 2 week wait for assessment and 50-70% increased uptake of the service compared to local community clinics;
- Improved support with goals of therapy linked to class targets; and
- Increased knowledge, skills and confidence of teaching staff in identifying and supporting children in the classroom.

4.2 Delivering Safe and Effective Practice and Care

This focused on two key areas:

- Risk assessment and management; and
- Clear governance and accountability frameworks (where AHPs interface with other service providers – relationships and interactions must be clearly defined).

A good practice example from community care was highlighted:⁵²

Dietetics - Dietitians as Home Enteral Tube Feeding (HETF) Co-ordinators have improved the quality of care for patients across Southern HSC Trust. They act as a single point of contact for patients, families/ carers, other professionals and external agencies to support people with feeding tubes at home. Working across the primary and secondary care interface they have been shown to reduce the risk of medical emergency callouts.

⁵¹ A Strategy for the Allied Health Professions in Northern Ireland 2012-2017, Department of Health, Social Services and Public Safety, pages 24-25, <https://www.health-ni.gov.uk/publications/improving-health-and-well-being-through-positive-partnerships-strategy-allied-health>

⁵² As above, page 33

4.3 Maximising Resources for Success

This focused on two key areas:

- Innovation and service modernisation; and
- Effective leadership and also working in partnership with colleagues to develop integrated care.

Good practice examples from community and primary care were highlighted:⁵³

Led by Occupational Therapy - “Living your life to the full” A Southern HSC Trust Reablement initiative for older people targeted at maximising their independence. This service aims to help support people to regain the ability to live as independently as possible reducing their need for support in the future. An average of 50% of clients were being discharged without needing other services.

Physiotherapy – Self Referral – It was proposed that self-referral to physiotherapy for people with MSK Disorders can stop people going off work, get people back to work, reduce GP visits, releasing capacity for other priorities Cost savings from self-referral have been realised across the UK, whereas a self-referral pilot from the South Eastern HSC Trusts is only presently under evaluation in NI.

4.4 Supporting and Developing the AHP Workforce

This focused on three key areas⁵⁴:

- Workforce planning;
- Learning and development; and
- Workforce development.

The strategy highlighted that investment in learning and development of physiotherapists, podiatrists and radiographers as supplementary prescribers would provide service users with more efficient access to medicines. Additional health care staff with prescribing power are likely to impact positively on pressures on GPs.

⁵³ A Strategy for the Allied Health Professions in Northern Ireland 2012-2017, Department of Health, Social Services and Public Safety, pages 39-40, <https://www.health-ni.gov.uk/publications/improving-health-and-well-being-through-positive-partnerships-strategy-allied-health>

⁵⁴ As above, page 47

5. Good Practice Services and Recommendations from Selected Allied Health Professions (UK)

5.1 Physiotherapy

The Chartered Society of Physiotherapy (CSP) state that General Practice Physiotherapists can effectively manage a Musculoskeletal (MSK) caseload in primary care - improving the patient experience and freeing up GP time. It is estimated that MSK conditions account for up to 30% of GP consultations. The CSP highlight that⁵⁵:

GPs are taking a lead in developing these roles as a welcome addition to their core teams. Although new, more than 8 out of 10 GPs already have confidence in this model.

General Practice Physiotherapists don't need supervising and have their own insurance cover. Many can independently prescribe and provide injection therapy, and soon should be able to issue fit notes.....Physiotherapists with advanced practice skills have a particular role to play in taking on many of the tasks currently carried out by GPs.....reducing the pressure on GPs...[and] physiotherapy services.

Regarding physiotherapy as a first point of contact in primary care, guidance was launched on 4th November 2016 jointly by the British Medical Association, Chartered Society of Physiotherapy and the Royal College of General Practitioners. It is designed for those who are thinking about developing physiotherapy as a first point of contact service and those who have already set up such a service and want to evaluate it. The guidance highlights that general practice physiotherapy services have generated benefits for patients, the local health economy, GPs and physiotherapists, including⁵⁶:

For Patients

- Quick access to MSK assessment, diagnosis, treatment and advice aiming to prevent short-term problems becoming long-term conditions;
- Improved patient experience with a shorter pathway and logistics, so patients have fewer appointments to attend, are less likely to miss appointments, or to suffer administrative errors;
- Longer appointment times for patients; and
- Aid patients' return to work, where appropriate.

⁵⁵ Implementing physiotherapy services in general practice: A guide for implementation and evaluation, Chartered Society of Physiotherapy, <http://www.csp.org.uk/publications/implementing-physiotherapy-services-general-practice-guide-implementation-evaluation>

⁵⁶ Implementing physiotherapy services in general practice: A guide for implementation and evaluation, Chartered Society of Physiotherapy, page 7, <http://www.csp.org.uk/publications/implementing-physiotherapy-services-general-practice-guide-implementation-evaluation>

For GPs

- Release of GP time through re-allocating appointments for patients with MSK problems;
- Reduced prescription costs;
- Increased clinical leadership and service development capacity; and
- Support in meeting practice targets.

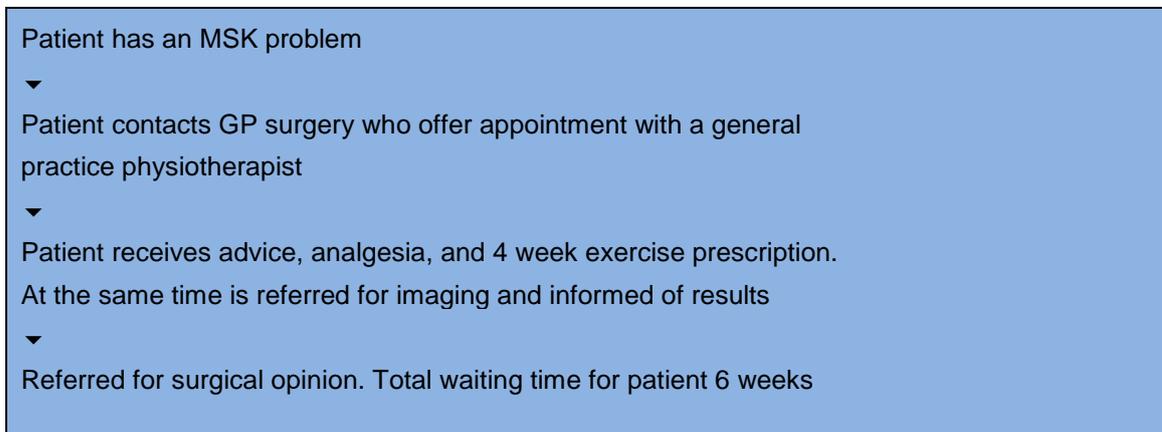
For the local health economy

- Reduced number of MSK referrals into secondary care and improved conversion rate to surgery when referrals are required;
- Improved use of imaging; and
- Improved links with local voluntary sector and patient groups.

For Physiotherapists

- Use of their professional knowledge and skills, including through stronger links with the multidisciplinary team; and
- Opportunities to develop and make use of their scope of practice and skills e.g. independent prescribing, injection therapy and imaging referral rights.

The guidance illustrates a traditional MSK patient pathway (with around seven steps) and the reduced four step MSK pathway using physiotherapy as a first point of contact service⁵⁷:



A good practice example of physiotherapists working as 'extended scope practitioners' in central Scotland was recently highlighted by the CSP. The service was prompted by a GP shortage in the area and two physiotherapists were seconded from the local Health Board into a practice in Stirling and two into a practice in Grangemouth (near Falkirk).

⁵⁷ Implementing physiotherapy services in general practice: A guide for implementation and evaluation, Chartered Society of Physiotherapy, information extracted from page 6, <http://www.csp.org.uk/publications/implementing-physiotherapy-services-general-practice-guide-implementation-evaluation>

The physiotherapists in these practices rarely offer hands-on physiotherapy but decide on the best pathway for the patient, including offering information leaflets or showing them exercises; referring on to mainstream physiotherapy services, orthopaedics, pain or rheumatology clinics; or determining whether they can self-manage. Preliminary results from an ongoing audit show that three patients in four were able to self-manage their MSK condition subsequently, about one in 20 received a steroid injection in the initial tranche, while two per cent were referred to orthopaedics and six per cent needed some form of imaging. Of the 858 patients assessed, just 13 cases were classed as being 'inappropriate'.⁵⁸

5.2 Occupational Therapy

During 2015-16, Occupational Therapists (OTs) in NI gathered data to demonstrate how their services enable people to avoid hospital admission or to facilitate discharge so they can return home. The culmination of this work is the report published by the College of OTs, launched on 11th November 2016, *Reducing the pressure on hospitals – A report on the value of occupational therapy in Northern Ireland*. The report focuses its recommendations in three areas – reducing admissions to hospital, reducing time in hospital and successful transition and discharge and a range of these are discussed below:

To prevent falls-related admissions, there must be increased partnership working between OT services and ambulance services when responding to falls⁵⁹:

The report highlights that falls are the most common cause of death from injury in the over 65s and are the single biggest reason for ambulance call-outs (40%) for emergency hospital admissions for older people. Specific examples quoted in the report of OTs work in this area include⁶⁰:

- **Southern HSC Trust 'Acute Care at Home' Team** (who respond to falls) - a consultant-led community service to deliver acute, non-critical care available to patients over 65 in their own home, nursing or residential setting. There is a response target of two hours from referral to treatment, which provides rapid access to senior medical, nursing and AHPs, including OTs who play a key role in the assessment, treatment and clinical management of patients; and
- **Falls Response Service, East Lancashire NHS Hospitals Trust and North West Ambulance Service (England):**

⁵⁸ McMillan, I. A. (2016) Stirling success for physios in two Scottish GP practices, CSP News, 1 June 2016, <http://www.csp.org.uk/frontline/article/stirling-success-physios-two-scottish-gp-practices>

⁵⁹ Reducing the pressure on hospitals, A report on the value of occupational therapy in Northern Ireland, College of Occupational Therapists, November 2016, page 10, <https://www.cot.co.uk/reducing-pressure-hospitals-%E2%80%93-report-value-occupational-therapy-northern-ireland>

⁶⁰ As above, pages 8-11

In Lancashire, in the 12 months before January 2016, 78% of people who received an innovative joint assessment between a paramedic and an OT were able to remain at home. This partnership is called the Falls Response Service (FRS) and has been set up by East Lancashire NHS Hospitals Trust and North West Ambulance Service (NWAS)....the multidisciplinary team is able to simultaneously check for health concerns that need immediate attention as well as assessing what caused the fall and establishing future prevention measures.

All hospital at home schemes, rapid response and acute and emergency care services must have OTs embedded within the multidisciplinary teams, and this includes 'Home Treatment' teams for mental health⁶¹:

The Multidisciplinary Assessment team at Altnagelvin (established June 2016) works within the Emergency Department (ED) with OT also having a role within the Clinical Decision Unit for supporting discharge within 23 hours, where appropriate. The team is made up of OTs, social workers and physiotherapists and many of the assessments involve collaborative working. Currently hours of operation are Monday to Friday, between the hours of 09.00-17.00 with plans to implement on a seven-day basis. Of patients assessed by OTs within the ED - 109 patients were seen by OT from 1 June – 31 August 2016. Of these:

- 26% (n=28) were admitted to acute bed;
- 70% (n=76) were discharged home, of which: 5% of patients were discharged to an alternative setting i.e. rehabilitation bed. 42% were referred onto a range of community services.

Patients assessed by OTs within the ED and Clinical Decision Unit - 85 patients seen by occupational therapy from 1st July – 31 August, 2016. Of these:

- 31% of patients avoided admission to an acute bed.

Overall the report states that this equates to 284 bed days saved costing at £300 per bed day = estimated cost saving of £85,200.

All multidisciplinary admission and discharge teams across the hospital environment must include OTs, with therapy-led discharge planning for people with complex health needs. To ensure timely and successful discharge, commissioners and service providers must support the development of therapy-led services⁶²:

The report highlights that OTs play a critical role in patients' discharge home and are key in the resettlement of patients from long-stay hospitals preparing people to manage

⁶¹ Reducing the pressure on hospitals, A report on the value of occupational therapy in Northern Ireland, College of Occupational Therapists, November 2016, page 12, <https://www.cot.co.uk/reducing-pressure-hospitals-%E2%80%93-report-value-occupational-therapy-northern-ireland>

⁶² As above, pages 15-18

their conditions at home and to overcome barriers to daily living. The report highlights that this is pertinent to mental illness as well as physical illness, for example the Mental Health Crisis Service in the Western HSC Trust:

The Mental Health Crisis Service in the Western Trust has two acute admission wards; a Home Treatment Team and an acute day hospital. There are three OTs based in the acute day hospital as part of a multidisciplinary team who provide interventions for people who are stepped up from the Home Treatment Team, or for inpatients stepped down from the hospital. The acute day hospital provides services so that people can be supported in the community, thus avoiding admission to hospital or the need to spend less time there when admitted.... Before being discharged, patients are actively encouraged by the OTs to engage with community resources...

The report highlighted the work of two stroke units in NHS Grampian (England), one led by a consultant OT and the other following a medical model. In 2014 the median length of stay in the consultant OT- led unit was 28 days and 55 in the other. In 2015 - 27 and 59 days. Patients have reported increased satisfaction and improved ability to engage in their chosen occupations at home, at work and socially. OTs understand that older people, in particular⁶³:

do not perform well in a hospital environment, leading to a risk-adverse approach to discharge and delays whilst complex care packages are put in place or a residential place can be found. An assessment in the person's home often reveals a more realistic picture of their abilities...

Occupational therapy-led reablement services should expand to include all adults and provide a seven-day programme of care:

The report highlights that, when adequately resourced, reablement led by OT has been successful. The Reablement Project Board's Retrospective Longitudinal Audit in 2014 (NI) was cited, which aimed to determine how long service users benefited from a reablement episode and if 'successfully reabled how long the benefit lasts'. The report concluded that reablement should be rolled out to all adult services and that domiciliary services should adopt a reablement ethos.⁶⁴

5.3 Dietetics

The NI Board of the British Dietetics Society have highlighted that dieticians in NI are working actively to implement primary care pathways to allow a range of patients to be

⁶³ Reducing the pressure on hospitals, A report on the value of occupational therapy in Northern Ireland, College of Occupational Therapists, November 2016, page 18, <https://www.cot.co.uk/reducing-pressure-hospitals-%E2%80%93-report-value-occupational-therapy-northern-ireland>

⁶⁴ As above, page 19

treated in community settings and preventing further referral or hospital admissions. A number of potential pathways and good practice examples are now highlighted (provided by the NI BDA)⁶⁵:

- Irritable bowel syndrome (IBS) is a common, long-term condition of the digestive system and accounts for approximately 12% of all GP and 35% of Consultant Gastroenterologist referrals. Implementing an appropriate dietician-led primary care diet treatment pathway in NI would allow these patients to be effectively managed in community setting. This type of service has been tested across the UK with positive results and is currently being considered as part of Gastro Outpatient Reform Work being carried out with the Health and Social Care Board. It is proposed that such a service would achieve a range of benefits such as releasing up to 35 % of Gastroenterology new patient slots per year; avoid unnecessary secondary care investigations for many patients; and ensure management of IBS in primary care with support escalation of patients to Gastroenterology as identified by Advance Practice Dietitians;
- Prevention and management of malnutrition in care homes – Care Home residents commonly have a number of chronic illnesses including dementia and/or dysphagia. Their clinical and nutritional needs fluctuate and in the absence of on-going dietetic care it is known that 70% of residents can be on an inappropriate nutritional care plan at any point in time. Community Dietitians from the South Eastern HSC Trust, with the support of care home staff and dietetic assistants, are using a new model of working including the concept of a Virtual Ward Round to anticipate, avoid and manage malnutrition in Care home residents, with an estimated SE locality saving of £83,000 per year.
- Cow's Milk Allergy (CMA) Clinic - Primary care guidelines issued in 2013 resulted in an increase in referrals to dietetics in SE HSC Trust for Cow's Milk Allergy in infants from 22 in 2012 to 140 in 2014 and 230 in first 6 months of 2016. In response to this demand and the associated unmet health needs in infants, the SE HSC Trust developed a new model of working with funding from The Health Foundation. A structured patient education approach and group session format commenced in primary care settings in February 2016, providing multidisciplinary assessment and milk free dietary advice for parents of new patients as well as professional and peer support. The proposed long-term model is a dietetic-led, early intervention milk allergy clinic using group education, review to confirm diagnosis of CMA and identify infants requiring transfer to acute allergy services.

One of the key ways dieticians are impacting on primary care in England is through the role of the Prescribing Support Dietician who identifies malnutrition and manages it through a 'food first' approach and ensuring the appropriate prescribing of oral

⁶⁵ NI Board of BDA, briefing paper provided by email to RaiSe, 24/11/16, prepared by Pauline Mulholland Lead Dietician, SE HSC Trust, July 2016

nutritional supplements. The British Dietetic Association highlights that up to 75% of adult prescriptions for oral nutritional supplements were not appropriate based on relevant prescribing criteria.

This role involves assessing individual patients to update their nutritional care plan as well as working with carers, care homes and community services to provide training for staff on identification of malnutrition using nutritional screening.⁶⁶

NHS England highlights a range of good practice in the area of ‘commissioning excellent nutrition and hydration’ from a number of Clinical Commissioning Groups (CCGs). For example⁶⁷:

- Greenwich CCG – has used savings generated from reducing inappropriate use of nutritional supplements in nursing homes and primary care to pilot community dietitians in GP practices to identify and screen patients at risk of and review use of oral nutrition supplements; and
- Chiltern CCG and Aylesbury Vale CCG – has used a ‘food first’ approach with community dietitians with a care home to reduce pressure ulcers.

5.4 Podiatry

In 2014 the College of Podiatry published *Developing a Sustainable Podiatry Workforce for the UK - Towards 2030*, with the aim of informing and influencing organisations responsible for health workforce strategy across the UK.

The report highlighted the range of work that podiatrists undertake in foot health and the key areas of impact that they can make in primary care and areas of secondary care (traditionally carried out in orthopaedics) and that good podiatry practice is critical within a population increasing in age and numbers with long term conditions. It highlighted that podiatrists can make particular impact with:

- Older People including Dementia and Falls;
- Long Term Conditions; particularly foot problems associated with diabetes; and
- Public Health and Disease Prevention.

Areas of the profession are increasingly supporting practice previously undertaken by medical surgeons or physicians. The workforce report highlighted that⁶⁸:

- Podiatric surgery is delivering good outcomes and should become established as the primary route for most elective ‘orthopaedic’ foot and ankle procedures;

⁶⁶ Specialist Dietitians in Appropriate Prescribing of Nutritional Products in Primary Care (2015), BDA, Older People Prescribing Support Sub-Group, https://www.bda.uk.com/improvinghealth/healthprofessionals/keyfacts/tad_prescribv2

⁶⁷ NHS England, Commissioning excellent nutrition and hydration, www.england.nhs.uk/commissioning/nut/hyd/

⁶⁸ Developing a Sustainable Podiatry Workforce for the UK Towards 2030, April 2014, The College of Podiatry, page 5, <http://www.scpod.org/easysiteweb/getresource.axd?assetid=39486&type=0&servicetype=1>

- Independent prescribing would enable more timely care for patients, particularly with limb threatening foot infection;
- Podiatrists are established clinical leaders in wound debridement, management and prevention;
- Local anaesthesia is part of everyday practice, used to ensure patients can have disabling conditions remedied, without pain; and
- Diagnostic ultrasound and injection procedures used with biomechanic diagnostics are effective therapies used to improve musculo-skeletal function caused by trauma or disease.

5.5 Speech and Language Therapy

Speech and language therapists (SLTs) provide treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing.

The Royal College of Speech and Language Therapists (RCSLT) consider that with 'appropriate alignment and recognition' of their contribution, SLTs can make a substantial contribution to delivering cost effective solutions within community care to support the Health Minister's vision.⁶⁹

The RCSLT has almost 17,000 members, with around 500 in NI. The College highlight that SLT already have direct referral but that people are not aware that they can directly access SLT and often use the GP as the referral route⁷⁰:

Currently GPs often have to deal with concerned parents worried about their child's developmental milestones, speech and language attainment or behaviour. Often GPs refer these families to their health visitor who then refer on to speech and language therapy. Speech and language therapy services already have open referral and do not require a GP contact.

The RCSLT note that SLTs have a unique role in the management of dysphagia (swallowing problems) which reduces the risk of associated complications that may require hospital admission such as, chest infection, aspiration pneumonia, dehydration and malnutrition. SLTs have put together proposals for an extended primary care role in this regard to prevent hospital admission and facilitate discharge from hospital, including⁷¹:

- A 'rapid response dysphagia management service' for patients in the community presenting with high risk complications associated with dysphagia such as chest

⁶⁹ Briefing for the NI Assembly Health Committee review of the impact of the allied health professions to community care, 24/11/16, provided by email to Dr Janice Thompson, RaISe, NI Assembly by Alison McCullough, Head of the NI Office, Royal College of Speech and Language Therapists.

⁷⁰ As above

⁷¹ As above

infection and dehydration as identified by the primary care team, acute care at home and respiratory teams;

- A 'rapid response dysphagia service' for those patients discharged from hospital to community who are identified as being of high risk of re-admission;
- An SLT primary care based model to private nursing homes by providing education programmes to improve management of residents with dysphagia and reduce the number of nursing home residents attending A&E with chest infections and dehydration.

The RCSLT highlight that SLTs have a key role to play in the emerging field of treating 'vocal cord dysfunction' (VCD), which can often be mistaken for asthma leading to many years of inappropriate treatment. There is evidence that once VCD is diagnosed, SLT is the cornerstone for its treatment and management. It is proposed that including SLTs in asthma clinics may significantly reduce the medicines cost for some individuals.⁷²

The RCSLT for NI have a range of innovative projects in place in terms of early intervention in primary care and community settings, which aim to provide timely care and ease pressure on GPs or prevent hospital admissions, including:

- *Reversing the Effects of Socio-Economic Deprivation on Child Language Skills in the Limavady Neighbourhood Renewal Area.* An initial screen of 303 children in nursery and primary one indicated that 68% of children were demonstrating some level of language delay. In July 2014 funding from the Community Education in Partnership initiative allowed the secondment of a Band 7 SLT from the Western HSC Trust to deliver a school programme of intervention on a weekly basis. This can take the form of⁷³:
 - Whole class language enrichment groups
 - Smaller language groups for the more severely delayed children
 - Individual therapy; and
 - Training for parents, teaching assistants and teachers;
- 2 Rhymes by 2 – an early language partnership approach in Downpatrick – local studies found that 46% of children in Downpatrick were entering school with language delay. The programme involves parents, health visitors, SLTs, family support workers and Sure Start. It used a series of key messages provided in

⁷² Briefing for the NI Assembly Health Committee review of the impact of the allied health professions to community care, 24/11/16, Appendix 3 (case study by Catherine Stewart and Shelley Bolton *Speech and Language Therapists, Belfast Health and Social Care Trust*), provided by email to Dr Janice Thompson, RaISe, NI Assembly by Alison McCullough, Head of the NI Office, Royal College of Speech and Language Therapists.

⁷³ Briefing for the NI Assembly Health Committee review of the impact of the allied health professions to community care, 24/11/16, Appendix 1, provided by email to Dr Janice Thompson, RaISe, NI Assembly by Alison McCullough, Head of the NI Office, Royal College of Speech and Language Therapists.

'bite-size chunks' to help parents recognise the value of communication from birth to two years.⁷⁴

5.6 Orthoptics

Orthoptists investigate, diagnose and treat disorders of binocular single vision (e.g. squints) and problems relating to reduced vision. This may be due to amblyopia (lazy eye) and/or the need for glasses. Orthoptists are also involved with assessing for abnormal eye movements caused by a nerve palsy, injury to the eye or diseases affecting the muscles in the eye.⁷⁵

Many orthoptists are hospital-based so patients will be referred to them by GPs. However, some orthoptists do work in the community – for example, visiting primary schools to conduct vision tests to assess whether children have any difficulties with their vision that will need to be treated.

For example, the range of outpatient orthoptic services provided by the Western HSC Trust indicates that these AHPs in NI work between primary and secondary care. For children and adults are held at the Orthoptic department at Altnagelvin, Tyrone County and the South West Acute Hospital, with satellite clinics for children at various other locations such as Limavady, Shantallow, Fintona and Irvinestown. The Trusts also provides an Orthoptic service to the following⁷⁶:

- Ophthalmology clinics throughout the region;
- Hospital Optometry service;
- Acute medicine;
- Community Paediatrics / child development clinics (Northern sector);
- Primary Vision assessment programme to special schools in the area;
- Primary School Vision Screening Service, delivered by school nurse; and
- Manage the visual field service, delivered by the Orthoptic assistants in Altnagelvin, Tyrone County and South West Acute Hospital.

6 Discussion and Challenges

'Integrated working' between primary and community care, hospital specialists and social services has been the key policy direction for reform of health and social care in

⁷⁴ Briefing for the NI Assembly Health Committee review of the impact of the allied health professions to community care, 24/11/16, High 5, RCSLT Manifesto Briefing – Children (Vivienne Fitzroy – NI Policy Office RCSLT), provided by email to Dr Janice Thompson, RalSe, NI Assembly by Alison McCullough, Head of the NI Office, Royal College of Speech and Language Therapists.

⁷⁵ Orthoptics, Western Health and Social Care Trust, <http://www.westerstrust.hscni.net/services/2505.htm>

⁷⁶ As above

NI for at least the past decade. Policy and strategy has clearly highlighted the need for greater use of the skilled AHP workforce to make 'integrated working' a success.

In NI and across the UK the AHP workforce are expected to play a key role in meeting the challenges facing health and social care sector systems. The Minister for Health has recently highlighted that in NI AHPs will have a vital role to play in the multidisciplinary teams planned for primary care as part of *Health and Wellbeing 2026, Delivering Together*⁷⁷,

Quite often, AHPs can provide services at primary care level that obviously mean that people do not need to be referred to hospitals.... In future, AHPs will have a key role to play in the multidisciplinary teams that I am talking about. I want them to know that I value what they do and that they will be a key part of the multidisciplinary teams in future...⁷⁸

It has recently been stated that AHPs are highly trained and professionally autonomous practitioners,

yet too often their vital contribution is marginalized in a public discourse that tends to refer only to 'doctors and nurses'...This needs to change.⁷⁹

Each AHP has its own professional body and there is also a UK-wide Allied Health Professions Federation (AHPF), who provided key evidence, regarding the role of AHPs in the reform agenda in NI, to the Health Committee's Workforce Planning Review in the previous mandate⁸⁰.

This paper has shown that in recent years AHPs in NI have consistently highlighted the good practice that they bring to driving forward the reform agenda including in self-referral, seven-day working, reablement and rehabilitation and in the education sector (particularly early intervention and speech and language).

However, the AHP sector has clearly highlighted the difficulties it faces in terms of lack of recognition in NI of paramedics as AHPs and lack of representation at senior policy-making and decision-making level. This also holds true across the UK, for example, in England there is one chief professional officer (currently Suzanne Rastrick), supported by a small team, to advocate for all the AHPs in England.⁸¹

⁷⁷ Health and Wellbeing 2026, Delivering Together, Department of Health (NI) (25th October 2016), <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

⁷⁸ Transformation of Health and Social Care: Mrs Michelle O'Neill MLA (Minister of Health), 27th October 2016, Committee for Health, Official Report (Hansard), page 9, <http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx>

⁷⁹ Oliver D. (December 2015) Allied Health Professionals are critical to new models of care, The King's Fund blog, <https://www.kingsfund.org.uk/blog/2015/11/allied-health-professionals-new-models-care>

⁸⁰ Review of Workforce Planning in the Context of Transforming Your Care, Committee for Health, Social Services and Public Safety, <http://www.niassembly.gov.uk/assembly-business/committees/archive/health-social-services-and-public-safety/reports/>

⁸¹ Oliver D. (December 2015) Allied Health Professionals are critical to new models of care, The King's Fund, <https://www.kingsfund.org.uk/blog/2015/11/allied-health-professionals-new-models-care>

In NI the AHPF highlighted to the Health Committee that ‘influence’ at a senior level was also an issue for them⁸²:

there is only one AHP adviser....So, even in the trusts, there is no model whereby AHPs, strategically, are positioned sufficiently to allow the agents of change, in band 5, 6 and 7 posts, to make a change. We are not consistently sitting round the table.

Internationally, Australia is one country which has recognised the importance of AHPs driving change at system and organisational levels. At health service organisational level, the Director of Allied Health is active at Board level and sits on the top management team, where strategic and resourcing decisions are made with medical and nursing leaders. At systems level each jurisdiction in Australia (federal, state and territory), has the equivalent of a Chief Allied Health Officer who works with the Directors of Allied Health at organisational level and also nationally through the Australian National Allied Health Committee to share innovation. They are also linked to the International Chief (Allied) Health Professions Officers network.⁸³

This paper has highlighted a range of examples of AHPs working more widely in primary and community care to alleviate pressures and prevent hospital admissions. The most widely cited and implemented to date has been the self-referral model to physiotherapy.

A report prepared in 2015 by the RAND Corporation for Health Education England – Primary Care Workforce Commission noted that extending the role of AHPs within primary care has been promoted as one part of a solution to the challenges facing the primary care workforce but that ‘little seems to be known about the impact of extending the roles of AHPs on patient health outcomes’.⁸⁴ The report highlighted a range of research in this area, noting positives and challenges⁸⁵:

- A recent study in 2014 found that the introduction of a self-referral pathway for physiotherapy is both feasible and cost effective and that it results in the delivery of comparable care – as mentioned in section 3.1 such pilots began in NI in the South Eastern HSC Trust in 2015;
- Some individual studies over the past decade suggest that particular AHPs can provide comparable care to that of traditional providers with published data

⁸² Review of Workforce Planning in the Context of TYC: Allied Health Professionals Federation NI, NI Assembly, Committee for HSPSSP, 27 May 2015, NIA 268/11-16, pages 143-155, <http://www.niassembly.gov.uk/assembly-business/committees/archive/health-social-services-and-public-safety/reports/>

⁸³ Boyce, R. Research Academic and Consultant, Brisbane, Australia, commenting on Oliver D. (December 2015) Allied Health Professionals are critical to new models of care, The King’s Fund, <https://www.kingsfund.org.uk/blog/2015/11/allied-health-professionals-new-models-care>

⁸⁴ Bienkowska-Gibbs T et. Al. (2015) New organisational models of primary care to meet the future needs of the NHS, RAND Europe, http://www.rand.org/pubs/research_reports/RR1181.html

⁸⁵ As above, page 6

suggesting that self-referral to physiotherapy could be a cost effective alternative to consultation with a GP⁸⁶:

However, these studies do not fully address the overall impact of introducing physiotherapy into general practice on GP consultation patterns and hence on overall NHS costs;

- A systematic review (2012) on the barriers to and facilitators of routine outcome measurement by AHPs found that the importance of measuring outcomes is well recognised within the AHPs, but there may be issues in practice with AHPs' knowledge of, and confidence in, using outcomes measures and the lack of organisational support for their use.

Section 3.3 of this paper noted a recent report from the Nuffield Trust, which found that equipping the existing non-medical workforce with additional skills is the best way to develop the capacity of the workforce.⁸⁷ The report highlighted one study estimating that up to 70 per cent of primary care physicians' work could be taken on by other health care professionals such as nurses or AHPs, and another systematic review has found that direct access to physiotherapists leads to improved patient outcomes and decreased costs, including physiotherapists assessing orthopaedic outpatients.⁸⁸

However, the Nuffield report also clearly highlighted the challenges of developing extended roles for staff, including for AHPs,⁸⁹ such as the risks of duplication of work; patient, staff, GP and senior management buy-in; time and money to develop new extended roles; the difficulty of determining true cost savings to the health sector; and issues around regulation and insurance for new extended roles.

In 2013 a King's Fund blog article commented that AHPs could be more visible in promoting their roles and skills.⁹⁰ More recently in England this challenge is being tackled. In April 2016 all AHPs in England were invited to take part in an online workshop to share views on how they can deliver future care in England in the NHS, in local authorities, housing, private practices and the voluntary sectors.⁹¹ Analysis of over 10,000 ideas, comments and votes during this phase resulted in an emerging 'Mandate for Change', on which wider views were sought via a second online workshop in July 2016.⁹²

⁸⁶ Bienkowska-Gibbs T et. Al. (2015) New organisational models of primary care to meet the future needs of the NHS, RAND Europe, page 6, http://www.rand.org/pubs/research_reports/RR1181.html

⁸⁷ Imison C. et.al. (2016), Reshaping the Workforce to Deliver the Care Patients Need, Nuffield Trust in association with NHS employers, <http://www.nuffieldtrust.org.uk/publications/reshaping-the-workforce>

⁸⁸ As above, page 34

⁸⁹ As above, pages 35-36

⁹⁰ Oliver, D. (2013), Let's hear it for allied health professionals, The King's Fund blog, <https://www.kingsfund.org.uk/blog/2013/08/lets-hear-it-allied-health-professionals>

⁹¹ Your chance to shape our mandate for change – Suzanne Rastrick, NHS England News, 11/04/2016, <https://www.england.nhs.uk/2016/04/suzanne-rastrick-5/>

⁹² Have your say about the Mandate for Change – Suzanne Rastrick, NHS England News, 30/06/14, <https://www.england.nhs.uk/2016/06/suzanne-rastrick-11/>