

Focus on: Allied health professionals

Can we measure quality of care?



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About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing. Developed in partnership by the Nuffield Trust and the Health Foundation, the programme provides in-depth analysis of key topics and tracks an extensive range of quality indicators. It aims to provide an independent picture of the quality of care, and is designed to help those working in health and social care to identify priority areas for improvement. The programme is primarily focused on the NHS and social care in England, but will draw on evidence from other UK and international health systems.

The QualityWatch website **www.qualitywatch.org.uk** presents key indicators by area of quality and sector of care, together with analysis of the data. This free online resource also provides research reports, interactive charts and expert commentary.

About this report

 QualityWatch Focus On reports are regular, in-depth analyses of key topics; these studies exploit new and innovative methodologies to provide a fresh view of quality in specific aspects of health and social care. This QualityWatch Focus On report explores how best the quality of care delivered by allied health professionals can be measured, and presents the key findings from the available data.

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Contents

| | |
|--|----|
| List of figures and tables | 2 |
| Summary | 3 |
| 1 Introduction | 6 |
| 2 What are allied health professionals? | 7 |
| 3 Capacity | 9 |
| 4 Effectiveness | 18 |
| 5 Access | 20 |
| 6 Safety | 25 |
| 7 Person-centred care and experience | 26 |
| 8 Equity | 27 |
| 9 Developing information about AHPs | 28 |
| 10 Conclusion and recommendations | 31 |
| References | 32 |
| Appendix: Allied health professionals and the work they do | 35 |

List of figures and tables

Figures

| | |
|---|----|
| Figure 3.1: Number of AHPs registered with the Health & Care Professions Council, 2013 | 9 |
| Figure 3.2: Trends in the number of AHPs registered with the Health & Care Professions Council, 2000–2013 | 10 |
| Figure 3.3: Percentage change in the number of full-time equivalents for staff groups, 2002–2013 | 11 |
| Figure 3.4: Percentage change in the number of AHPs registered with the Health & Care Professions Council compared with full-time equivalent AHPs working in the NHS, 2002–2013 | 12 |
| Figure 3.5: Total number of AHPs per 1,000 people in each strategic health authority, 2012 | 12 |
| Figure 3.6: Percentage of NHS staff feeling satisfied with the quality of the work and patient care they are able to deliver, 2008–2013 | 15 |
| Figure 3.7: Percentage of NHS staff agreeing that their role makes a difference to patients, 2008–2013 | 16 |
| Figure 4.1: How the AHP contribution to stroke care has changed, 2001–2013 | 19 |
| Figure 5.1: Distribution of AHP outpatient episodes by age and sex, 2012/13 | 21 |
| Figure 5.2: Distribution of the number of appointments for patients, 2012/13 | 21 |
| Figure 5.3: Appointments and waiting times for the main AHP treatment specialties, 2012 | 22 |
| Figure 5.4: Ambulance response times, April 2011 to December 2013 | 23 |
| Figure 9.1: ‘Theogram’ showing an event timeline for health and social care use for one person over a three-year period | 30 |

Tables

| | |
|---|----|
| Table 2.1: A brief summary of AHP roles | 8 |
| Table 3.1: Number of AHPs per 1,000 people for each profession in each strategic health authority, 2012 | 13 |

Summary

In this report, we explore the quality of care and services delivered by allied health professionals (AHPs). AHPs are a group of autonomous practitioners who work with many other professionals and at many points along the care pathway. Although the majority of AHPs work in the National Health Service (NHS), and accounted for a salary bill exceeding £2 billion in 2013, many also work in the private and voluntary sectors. AHP roles span many domains of care, including:

- prevention
- health promotion
- diagnosis
- treatment
- support
- enabling independence.

Integration is a given for most AHPs, whose roles very often depend on interfaces across care teams – and across sectors of care.

Yet despite the size and importance of the AHP workforce, AHPs are rarely the subject of major policy debates and there is a concern that their contribution to care is often hidden, overlooked or potentially undervalued. In this report we look at AHPs collectively and also at the different AHP groups, which include:

- chiropodists/podiatrists
- dietitians
- dramatherapists and art and music therapists
- occupational therapists
- orthoptists
- paramedics
- physiotherapists
- prosthetists and orthotists
- radiographers
- speech and language therapists.

While these are grouped together under the collective ‘AHP’ banner, it is important to note that these are distinct professions with diverse roles.

Our analysis set out to understand what is happening in terms of the quality of care and services that AHPs deliver. In undertaking this work, we found that:

- AHPs made up 6 per cent of the NHS workforce in 2013, with an estimated staff cost of over £2 billion. Yet there is very little systematic information at a national level about the quality of care delivered by AHPs. In fact, there is a shortage of even basic information about activity, waiting times and appointments at a

national level to inform comparative analyses. This is especially problematic in areas outside of hospital care.

- In 2013, there were 172,686 registered AHPs and 64,377 full-time equivalent (FTE) AHPs working in the NHS. From 2002 to 2013, the numbers of AHPs increased by 53 per cent for the number of registered practitioners, and by 34 per cent for those FTE practitioners working in the NHS. There is some evidence that suggests an increased share of AHP activity in the voluntary and private sectors since 2009.
- There are large variations between the number of AHPs working in the NHS per 1,000 people across the different AHP professions and across regions in England. In 2012, in the North East there were over 1.43 AHPs per 1,000 people, in contrast to 0.95 AHPs per 1,000 people in the East of England. However, these comparisons are only crude and there are no systematic ways of standardising for population needs across professional groups.
- Information from national Hospital Episode Statistics data suggests that in 2012/13, AHPs were collectively one of the largest providers of outpatient appointments, with 7.5 million episodes (9.9 per cent of all appointments). Over 50 per cent of these appointments were attended by people aged 61 and over, with the main treatment specialties being physiotherapy and occupational therapy.
- A key area where measuring the quality of AHP care has driven improvement over time is stroke care. Since AHP measures were included in the National Stroke Audit in 2001, the rate of compliance with standards has greatly increased. For example, between October and December 2013, 94 per cent of patients admitted to hospital with stroke had a physiotherapy appointment within 72 hours (compared with 59 per cent in 2001), 86 per cent had an assessment by an occupational therapist within four working days (no comparative data are available) and 79 per cent had a swallowing assessment by a speech and language therapist within 72 hours (compared with 62 per cent in 2001).
- Generally, AHPs working in the NHS feel positively about their roles compared with the averages for all NHS staff. In 2013, 77.0 per cent of AHPs felt satisfied with the quality of their work – similar to all NHS staff – while 92.9 per cent felt that their role made a difference to patients, which was higher than the 89.7 per cent for all staff. However, paramedics were an exception. They reported high levels of work pressure, working extra hours, work-related stress, pressure to work when unwell, less agreement that their role made a difference to patients, and lower job satisfaction and motivation.

While these data show some key inputs to care, they are very limited in covering all aspects of the quality of care. One of our key observations from the analysis presented in this report is the importance of developing information systems that would collect consistent and comparable data on all aspect of the quality of care delivered by AHPs.

We suggest that a better understanding of both the levels of care and the quality of care provided by AHPs will be increasingly important in a financially constrained NHS. Improving the scope, consistency and availability of routine data will be important to understanding the contribution that AHPs make to high-quality care. Due to the nature of their work, many AHPs are well primed to address some of the key challenges facing the future of health and care, in

particular the need to understand the pattern of service delivery for patients with long-term conditions and more complex needs. As a group of professionals who work across care sectors, there is a real opportunity to create new or build on previous measures that assess quality in these areas. These could easily be applied to other health or care groups or the system as a whole; with a focus more on the patient pathway, not on the discrete parts.

While some work has already started to improve data collection on the quality of care delivered by AHPs, the future agenda needs to include:

- **Recognition of AHP activity in the implementation of community information systems.**

As the development of the Community Information Data Set and the Commissioning Data Set continues, it is important that AHPs are appropriately included, and opportunities to capture activity are identified and implemented. Although data on referral to treatment time are being collected, information on other aspects of care also need to be captured. It is equally important that AHPs are appropriately trained to collect meaningful and consistent data. This will include having access to technology to record the data, and the training and support needed for such systems.

- **The development of ways to link basic administrative information with care records.**

As the work of AHPs involves many settings and scenarios, it is important that data from individual professional encounters are not kept in isolated datasets but can be linked with other patient information in common care records. We have seen an example of how linked datasets can lead to improvements of care, and continuation of this work will build a richer and more accurate picture of the care and services that AHPs provide.

- **The development of ways to use information to quality-assure the care that AHPs deliver.**

Alongside better information on AHP activities, it is also important to ensure that this translates into improved practice, for example ensuring that benchmarking is used and areas of best practice are highlighted.

- **Continued development of AHP research.**

This includes understanding the quality of AHP care in two ways:

- by looking at the longer-term pathways of care and finding/understanding where and why variation exists
- by conducting specific studies that focus on shorter-term outcomes, in terms of physical health, social/psychological issues or activities of daily living. This could be specific to a profession, a condition or both.

'It is important that data from individual professional encounters are not kept in isolated datasets'

1

Introduction

There is much debate about how the health and care workforce deals with the pressures it faces – whether these arise from financial constraints or increasing needs/demands for services. Such debates typically focus on the work of doctors, nurses and managers, but there are other staff groups that play an important role in the delivery of care that are rarely discussed; groups such as allied health professionals (AHPs).

7.5 million
Number of
outpatient
appointments
with AHPs in
2012/13

AHPs are a group of 12 distinct professions, and together accounted for 6 per cent of the total National Health Service (NHS) workforce in 2013. This means that there were 1.2 full-time equivalent (FTE) AHPs working in the NHS for every 1,000 people in England; this compares with 2.6 for all doctors and 6.0 for nurses. We estimated¹ that just over £2 billion was spent on AHP salary costs in the NHS in 2013. We know that AHP appointments were one of the largest outpatient consultant specialties in 2012/13, with 7.5 million outpatient episodes; making up 9.9 per cent of all outpatient appointments that year.

As a collective group and as distinct professionals, AHPs' remit is diverse and far-reaching. They work in many settings with many other professionals. They also work for a range of funders: some work solely for the NHS or local authorities; while others work privately; or many, a mix of both. This presents some unique challenges in assessing the quality of AHP care.

There are a number of reasons why we should focus on AHPs at this time. We know that integration is an important part of current policy (Department of Health (DH), 2013), which aims to 'address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease' (Shaw and others, 2011, p. 3). However, we also know that measuring the impact and quality of integrated care is a challenge. AHPs are well placed to meet these future challenges, as many of these professionals deliver a large proportion of care to older people and those with more complex conditions. They also have the potential to understand person-centred, coordinated care as they work as key members of multidisciplinary, multi-agency teams.

In this report, in exploring the data on the impact of AHPs on the quality of care, we use six domains of quality – capacity, effectiveness, access, safety, person-centred care and experience, and equity (Leatherman and Sutherland, 2008) – as set out by the QualityWatch programme. First, in the next chapter, we look briefly at what AHPs are and the roles that they have.

1 Using NHS staff earnings estimates – Health & Social Care Information Centre (HSCIC), 2014a – and NHS Hospital and Community Health Service workforce statistics – HSCIC, 2013a.

2

What are allied health professionals?

AHPs are members of health and care teams who help to support care and treatment that can transform people's lives (NHS Careers, 2012). Within the broader group is a range of professional disciplines, so their remit is far-reaching. AHPs work in a variety of settings, can be first-contact or sole-contact practitioners, and work at multiple points in the care pathway – from diagnosis and prevention, to specialist disease management and rehabilitation (DH, 2008a). They work alone or with a range of other professionals: doctors, nurses, general practitioners (GPs), social workers and others; and in a range of settings, for example: hospitals, clinics, people's homes, schools and colleges.

Any practising AHP, whether privately or publicly funded, must be registered with the Health & Care Professions Council (HCPC). The HCPC ensures that all AHPs meet a standard of training, professional skills, behaviour and health, so that they are fit for practice (HCPC, 2013a). If complaints are made to the HCPC about a registered professional, it is the HCPC's responsibility to investigate whether that AHP is fit to practise, that is, whether they have the skills, knowledge and character to practise their profession safely and effectively. If the professional is deemed unfit to practise, the HCPC can put warnings against the individual on the register, enforce more training or supervision for the individual, suspend the individual for a period of time, or ultimately stop them from practising. As well as regulating the professions, the HCPC also provides standards of proficiency and conduct. Individual professional bodies also have their own standards and codes of conduct to ensure the proficiency of AHPs.

This report covers the following AHP groups:

- chiropodists/podiatrists
- dietitians
- dramatherapists and art and music therapists
- occupational therapists
- orthoptists
- paramedics
- physiotherapists
- prosthetists and orthotists
- radiographers
- speech and language therapists.

Most of these groups devote the majority of their time to managing people with chronic or long-term health problems; some, such as paramedics, work in urgent care; and some, such as radiographers, work to support diagnosis. Table 2.1 provides a brief description of the roles of each professional; for more detailed information, see the Appendix.

Table 2.1: A brief summary of AHP roles

| Professional | What they do |
|--|--|
| 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. |
| Dramatherapists and art and music therapists | <p>Dramatherapists 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.</p> <p>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.</p> <p>Music therapists facilitate interaction and development of insight into clients' behaviour and emotional difficulties through music.</p> |
| 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 | Ambulance service health professionals provide urgent and emergency care to patients. They assess and treat patients before transferring or referring them to other services, as appropriate. |
| 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. |
| Prosthetists and orthotists | <p>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.</p> <p>Orthotists design and fit orthoses (calipers, braces etc.) which provide support to part of a patient's body, to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing.</p> |
| Radiographers | <p>Diagnostic radiographers produce high-quality images on film and other recording media, using all kinds of radiation.</p> <p>Therapeutic radiographers treat mainly cancer patients, using ionising radiation and, sometimes, drugs. They provide care across the entire spectrum of cancer services.</p> |
| Speech and language therapists | Work with people who have communication and/or swallowing difficulties. |

Source: Allied Health Professions Federation, 2013

3

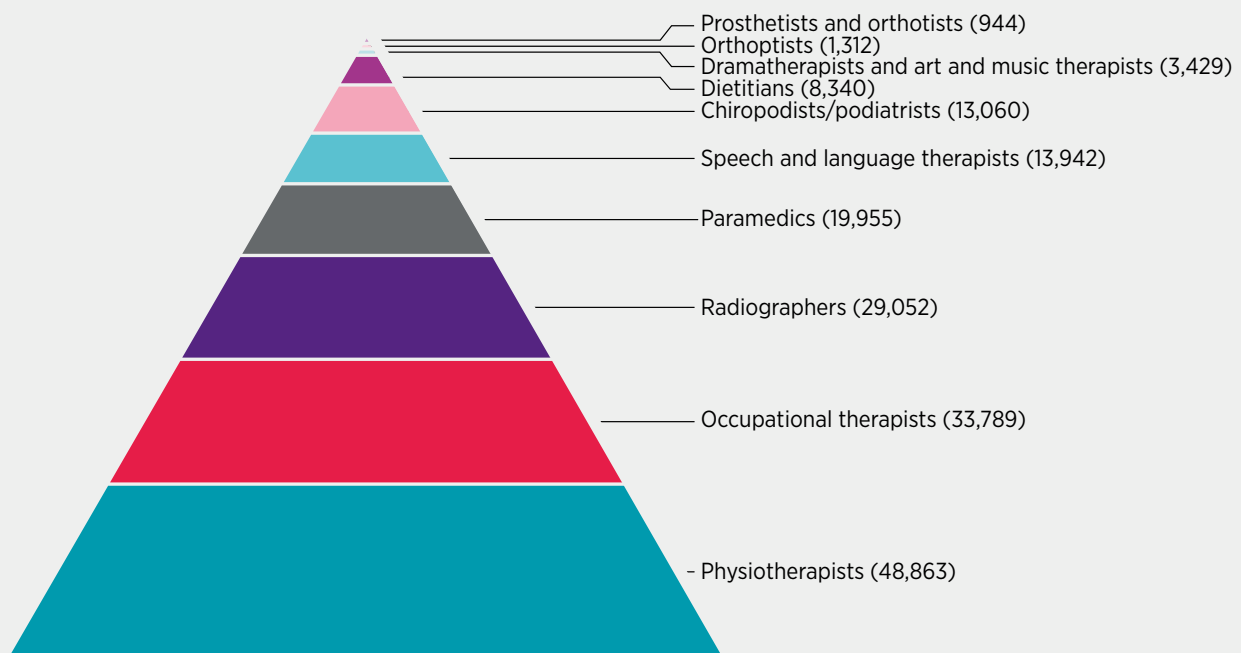
Capacity

172,686
Number of
registered AHPs
in 2013

In this chapter we look first at the number of AHPs registered with the HCPC. Collectively, AHPs are regulated by the HCPC and have to be registered with this council and comply with the associated standards and regulations (HCPC, 2013b). Figure 3.1 shows the number of professionals in each profession who were registered with the HCPC in 2013. In 2013, there were 172,686 registered AHPs in total. These data include publicly and privately funded AHPs, but there is little information on the proportion of AHPs who work privately (outside of the NHS) or, for those who work in both sectors, how their workload is split. The numbers in Figure 3.1 also include those who are not working but are still registered.

Looking at all those registered with the HCPC, in Figure 3.1 we see that the largest numbers in 2013 were physiotherapists (48,863) and occupational therapists (33,789). In contrast, there were less than 1,000 registered prosthetists and orthotists.

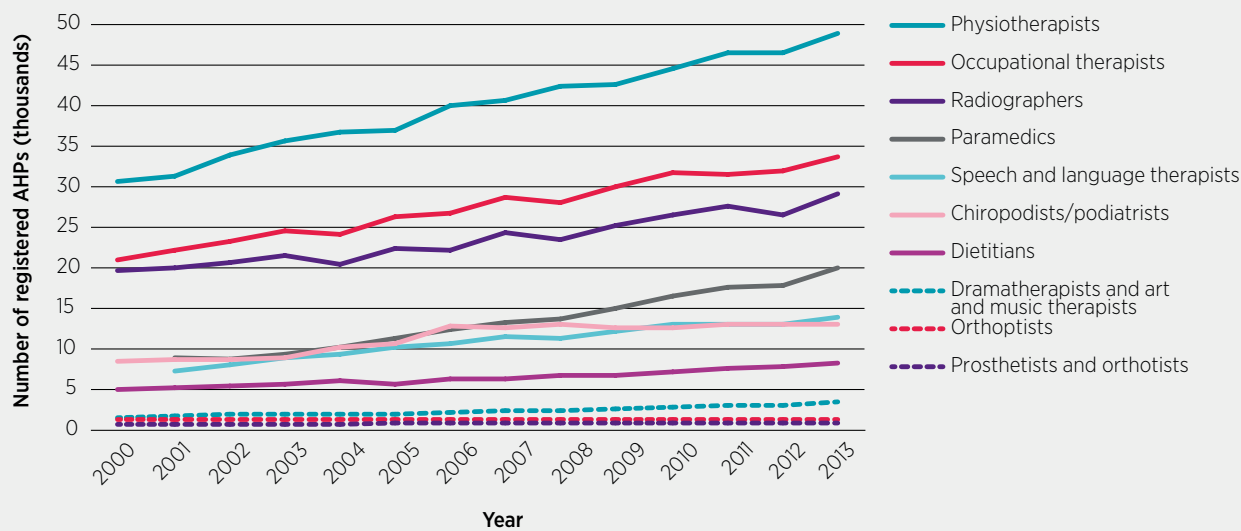
Figure 3.1: Number of AHPs registered with the Health & Care Professions Council, 2013



Source: Health & Care Professions Council, 2014

We also looked at how these numbers have changed over time. Figure 3.2 shows that for the majority of AHPs, the number registered with the HCPC has been increasing steadily since 2000. So, for example, between 2000 and 2013 the numbers of registered physiotherapists increased by 60 per cent and the numbers of occupational therapists by 61 per cent. The only exceptions to this general pattern of increase are podiatrists and orthoptists, whose numbers have remained steady since 2006.

Figure 3.2: Trends in the number of AHPs registered with the Health & Care Professions Council, 2000–2013



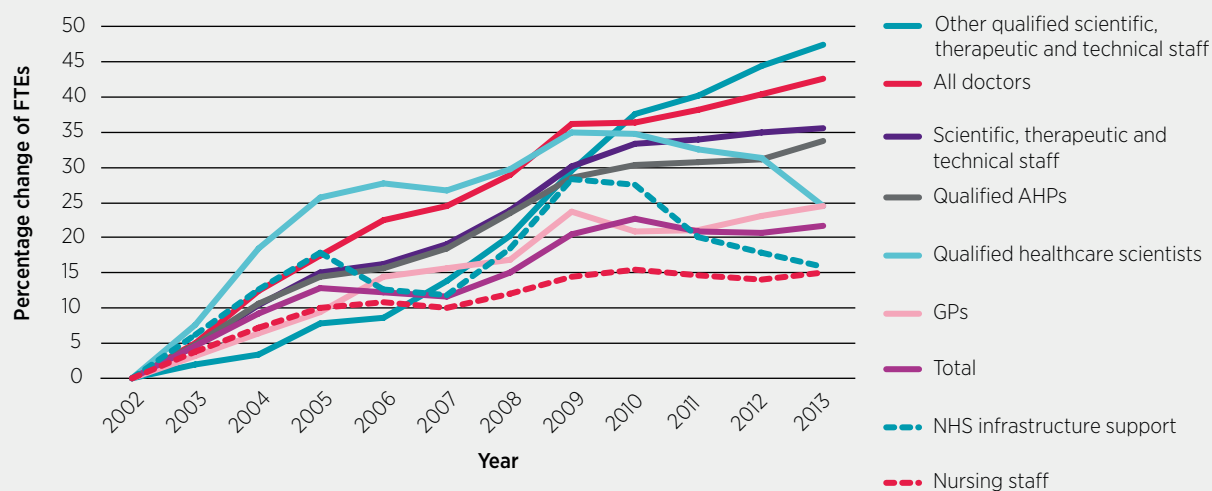
Source: Health & Care Professions Council, 2014

Using NHS workforce statistics (HSCIC, 2013a; 2014b), we know that in 2013, FTE AHPs accounted for 6 per cent of the total NHS workforce. Figure 3.3 shows the percentage change in the number of FTEs for staff groups in the NHS, from 2002 to 2013. During this period, the number of qualified FTE AHPs in the NHS increased by 33.7 per cent. Although the rate of increase appeared to slow down from 2010, the percentage change still showed an increase every year, which was not the case for all staff groups.

The number of FTE AHPs in the NHS increased from 44,594 in 2000 to 64,377 in 2013. This increase is consistent with the aims of the 2000 reform: *Meeting the Challenge: A strategy for the allied health professions* (DH, 2000). This reform noted that: ‘the role of the AHPs has been too often undervalued and neglected’ (p. 5). To rectify this, the DH set a target that by 2004 there would be:

- ‘over 6,500 more therapists and other health professionals’
- ‘4,450 more therapists and other key professional staff being trained’ (p. 5).

From 2000 to 2004, the number of FTE AHPs in the NHS increased by 8,718 – exceeding this target (HSCIC, 2013a).

Figure 3.3: Percentage change in the number of full-time equivalents for staff groups, 2002–2013

Source: Health & Social Care Information Centre, 2013a; 2014b

NHS versus private and voluntary sectors

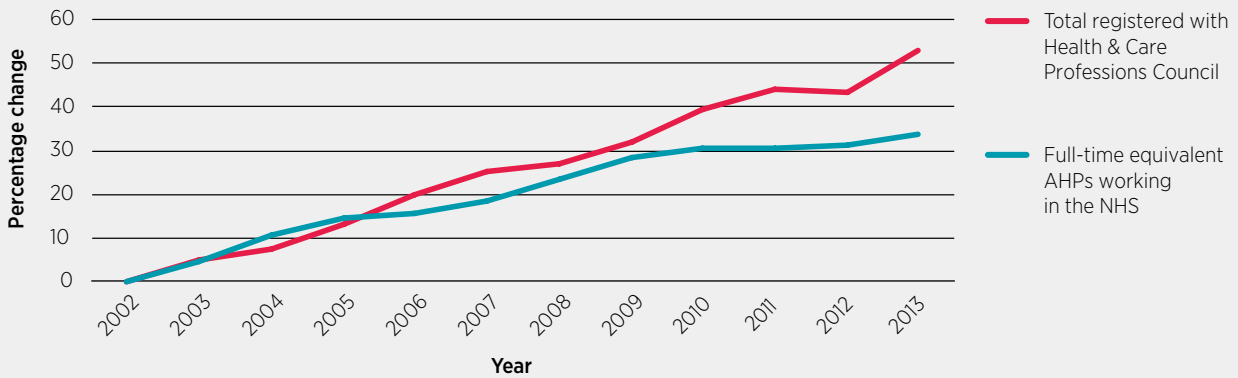
It is difficult to know how the AHP workforce is split between the NHS and private/voluntary sectors. The split varies by profession: some – such as radiographers and paramedics – work largely in the NHS, while others – such as podiatrists and physiotherapists – have greater numbers in other sectors. Research conducted in some of the professions gives an idea of this possible breakdown between publicly and privately funded AHPs. For example, the Royal College of Speech & Language Therapists conducted a census of its members this year and found that:

25 per cent reported that their primary role was not commissioned by the NHS. A further 22 per cent are estimated to be working in secondary roles not commissioned by the NHS. These roles were distributed across a number of areas such as; working in education, third sector charities, justice sector, research, as private practitioners or in social care. (Royal College of Speech & Language Therapists, forthcoming)

The situation is also made more complex as we also know that there has been an increased spend on non-NHS providers of community services (Lafond and others, 2014), which is likely to underplay the number of NHS-funded AHPs.

We cannot compare the HCPC registration numbers directly with the numbers of FTE AHPs working in the NHS, as those registered with the HCPC will include AHPs working in all sectors and those registered who are no longer working. However, we can compare how the rates have changed over time. Figure 3.4 shows the difference in the rates of change from 2002 to 2013 for AHPs registered with the HCPC and for FTE AHPs working in the NHS. By 2013, the increase in the number of HCPC-registered AHPs was greater than the increase in the number of FTE AHPs working in the NHS. Those registered with the HCPC had grown by 19 per cent more than FTE AHPs recorded in the NHS workforce. Up to 2009, the two figures increased at roughly the same rate, but since 2009 the increase in NHS numbers has been slower. While it is difficult to draw definitive conclusions, this could indicate that there has been more growth in non-NHS settings than NHS settings over the last few years.

Figure 3.4: Percentage change in the number of AHPs registered with the Health & Care Professions Council compared with full-time equivalent AHPs working in the NHS, 2002–2013

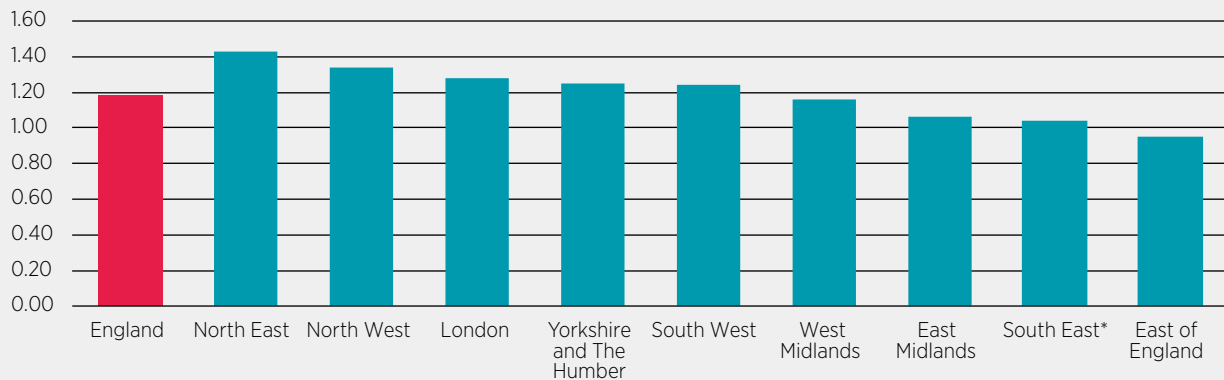


Source: Health & Social Care Information Centre, 2013a; 2014b and Health & Care Professions Council, 2014

AHP numbers relative to population size

The numbers of AHPs in the NHS can also be expressed relative to the size of the population (the number of FTE AHPs per 1,000 people) to give a crude indication of differences in supply across the regions of England. In 2013, on average, there were 1.2 AHPs working in the NHS for every 1,000 people; this compares with 2.6 for all doctors and 6.0 for nurses. Figure 3.5 shows the density (number of AHPs per 1,000 population) of AHPs in each strategic health authority (SHA) in 2012. There was some variation across England, with the East of England having the lowest with 0.95 AHPs per 1,000 people and the North East the highest with 1.43 per 1,000 people.

Figure 3.5: Total number of AHPs per 1,000 people in each strategic health authority, 2012





* The number of AHPs in the South East Coast and South Central are combined to form the number of AHPs in the 'South East', as population estimates are only available at the South East level.

Source: Health & Social Care Information Centre, 2013a and Office for National Statistics, 2013

Table 3.1 shows a crude ratio of the numbers of FTE AHPs in each allied health profession relative to the SHA population in 2012. As we have seen previously, physiotherapy is the largest allied health profession and so it is not surprising that physiotherapists had the highest density, at 0.35 FTEs per 1,000 people in England. However, they also had the biggest range across the SHAs, with the lowest seen in the East of England with 0.26 physiotherapists per 1,000 people; this is compared with 0.41 physiotherapists per 1,000 people in North East England. Despite the variation in density among the different AHP types and SHAs, the North East consistently had the highest density of the different AHP types. The lowest was seen in the East of England. While it is useful to look at the variation in these numbers, it is worth noting that these data only cover AHPs who work in the NHS; differences in levels of private/voluntary sector care are likely to vary, which would influence these numbers.

Table 3.1: Number of AHPs per 1,000 people for each profession in each strategic health authority, 2012

| AHP type | England | North East | North West | London | Yorkshire and The Humber | South West | West Midlands | East Midlands | South East* | East of England |
|--|---------|------------|------------|--------|--------------------------|------------|---------------|---------------|-------------|-----------------|
| Qualified AHPs in NHS | 1.18 | 1.43 | 1.34 | 1.28 | 1.25 | 1.24 | 1.16 | 1.06 | 1.04 | 0.95 |
| Qualified podiatry staff | 0.06 | 0.08 | 0.09 | 0.05 | 0.06 | 0.05 | 0.06 | 0.05 | 0.05 | 0.04 |
| Dietitians | 0.07 | 0.08 | 0.08 | 0.09 | 0.08 | 0.06 | 0.06 | 0.06 | 0.05 | 0.06 |
| Occupational therapists | 0.28 | 0.35 | 0.30 | 0.27 | 0.28 | 0.32 | 0.26 | 0.30 | 0.24 | 0.23 |
| Orthoptists | 0.03 | 0.02 | 0.04 | 0.03 | 0.03 | 0.03 | 0.04 | 0.02 | 0.02 | 0.02 |
| Physiotherapists | 0.35 | 0.41 | 0.39 | 0.37 | 0.37 | 0.39 | 0.35 | 0.31 | 0.31 | 0.26 |
| Diagnostic radiographers | 0.24 | 0.28 | 0.29 | 0.25 | 0.27 | 0.23 | 0.24 | 0.19 | 0.21 | 0.21 |
| Therapeutic radiographers | 0.04 | 0.05 | 0.04 | 0.05 | 0.04 | 0.05 | 0.04 | 0.04 | 0.04 | 0.05 |
| Dramatherapists and art and music therapists** | 0.01 | 0.01 | 0.00 | 0.01 | 0.01 | 0.01 | 0.00 | 0.00 | 0.01 | 0.01 |
| Speech and language therapists | 0.11 | 0.14 | 0.12 | 0.16 | 0.10 | 0.10 | 0.10 | 0.09 | 0.10 | 0.09 |
| Ambulance paramedics*** | 0.21 | 0.22 | 0.22 | 0.23 | 0.21 | 0.26 | 0.24 | 0.25 | 0.16 | 0.17 |

 Strategic health authority with the lowest density for each AHP type
 Strategic health authority with the highest density for each AHP type

* The number of AHPs in the South East Coast and South Central are combined to form the number of AHPs in the 'South East', as population estimates are only available at the South East level.

** Due to rounding, figures shown as zero indicate very low values but not necessarily zero.

*** One of the additional problems with AHP data is how the distinct professions are grouped. For example, Hospital and Community Health Service (HCHS) workforce statistics, which tell us about staff numbers in the NHS, group paramedics separately from all AHPs. There are no trend data available for paramedics but they are included here to give a regional comparison.

Source: Health & Social Care Information Centre, 2013a and Office for National Statistics, 2013

Ideally, we would look at how these densities vary according to the population needs in each area, for example the proportion of older people or the incidence of hip fractures or stroke. This would give a better understanding of whether these numbers are appropriate and, if not, to make further assumptions about people paying privately for AHP care or about whether this means that the quality of care suffers, for example people have to wait longer for an appointment. However, there are no established measures of need that span all the different care groups so such standardisation is not possible. It would be interesting to explore whether it is possible to establish some common descriptors of patient types within a population to build up such a model of expected needs.

AHPs' satisfaction with their work

The NHS Staff Survey has been running for a number of years and is one of the main ways to gather views of NHS staff at a national level. It can help to build a picture of staff experience, to look at change over time, and to compare different staff groups and organisations (NHS, 2013a). One key finding from the NHS Staff Survey combines answers from a number of questions to give 'the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver'. Figures 3.6a and 3.6b show, for the period 2008 to 2013, the percentage of NHS staff who felt satisfied with the quality of the work and patient care they were able to deliver. For all NHS staff, the percentage feeling satisfied generally increased, from 60.4 per cent in 2008 to 77.5 per cent in 2013. All AHPs – grouped here in the survey results with healthcare scientists, and scientific and technical staff – followed a similar pattern from 2008 to 2013. There was, however, some variation among the different AHP professions. Radiography had the highest percentage of staff feeling satisfied with the quality of the care they provided in every year, while occupational therapy had the lowest. Despite these differences, the percentage of staff feeling satisfied was higher in 2013 compared with 2008 among all AHPs, apart from art therapists and paramedics.

It is worth noting that art therapists had a small sample size compared with the other groups, reflecting the size of their workforce in the NHS; therefore the data for art therapists presented in Figure 3.6b were the most variable and had the biggest confidence intervals.

With regard to paramedics, they perform differently from the other professions on many of the Staff Survey questions. Although the data are not shown in this report, paramedics describe:

- high levels of work pressure
- working extra hours
- work-related stress
- pressure to work when unwell
- lower job satisfaction and motivation (NHS, 2013b; 2013c; QualityWatch, 2014a).

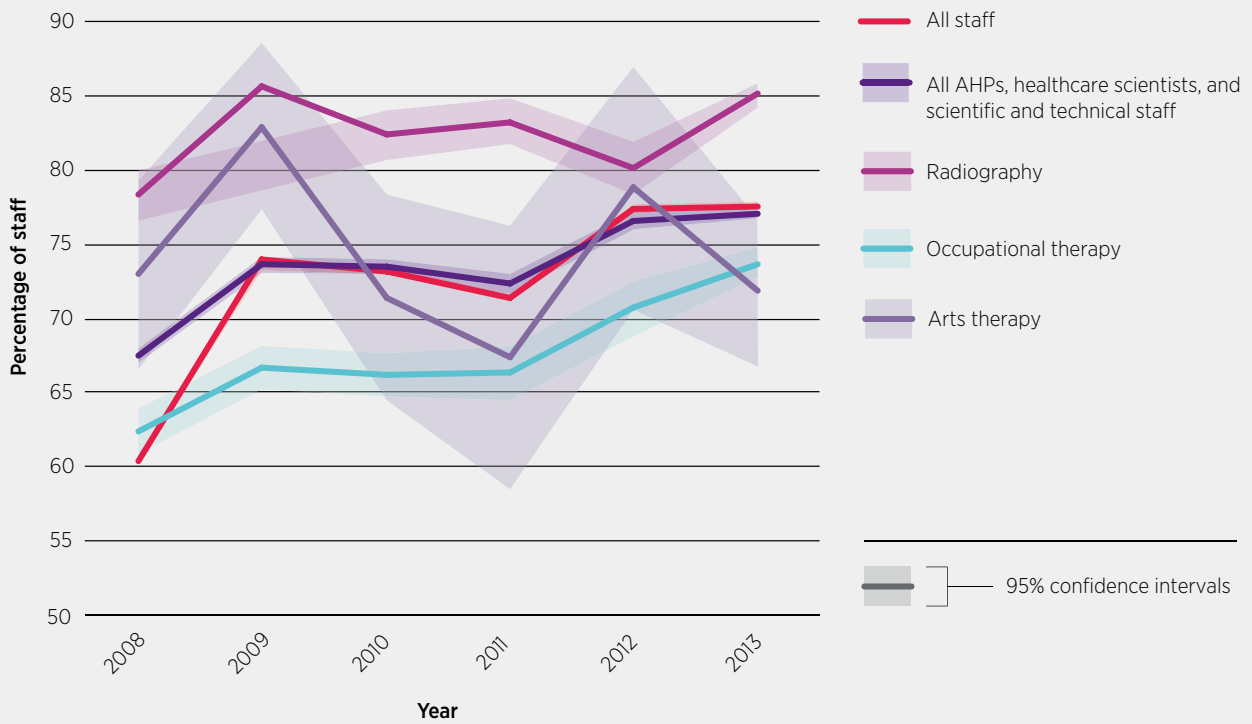
Some of these factors, such as high levels of work pressure, may be associated with paramedics working in urgent care settings; however, this is unlikely to account for the variation in all these areas.

Figure 3.6: Percentage of NHS staff feeling satisfied with the quality of the work and patient care they are able to deliver, 2008–2013

Figure 3.6a



Figure 3.6b



Source: National Health Service, 2013b; 2013c

Figure 3.7: Percentage of NHS staff agreeing that their role makes a difference to patients, 2008–2013

Figure 3.7a

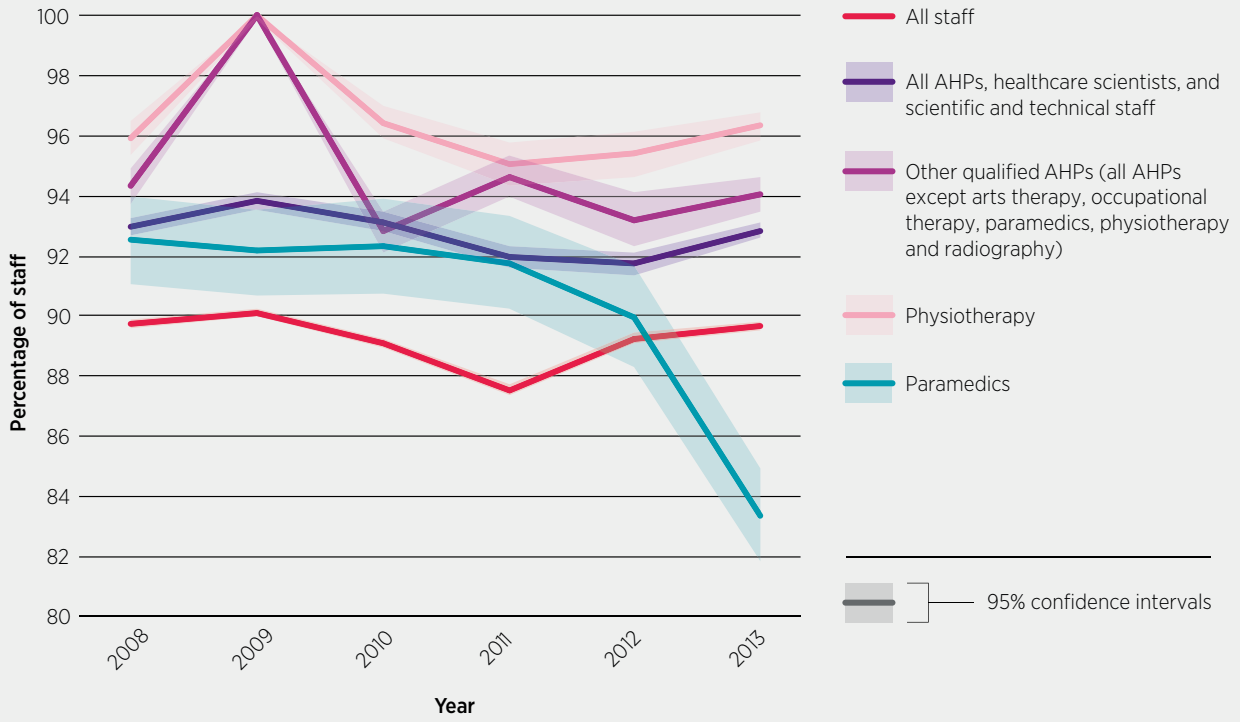
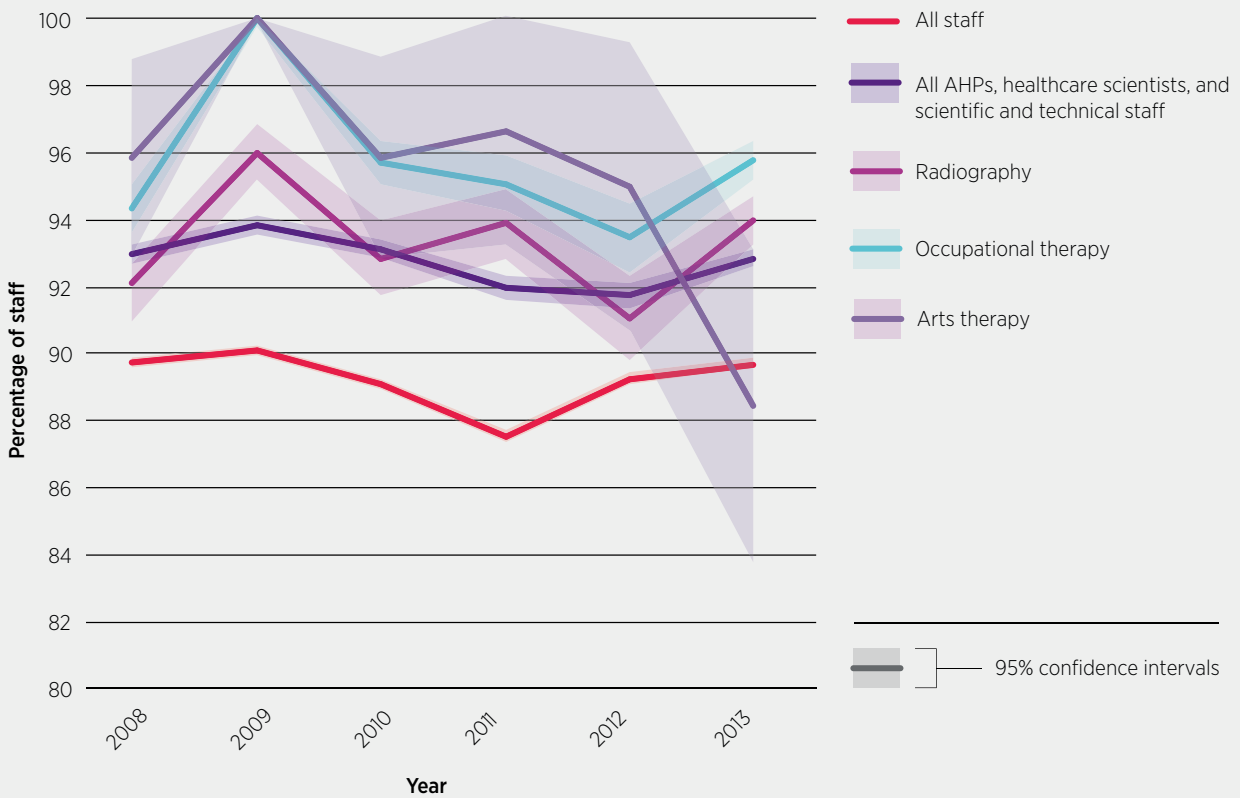


Figure 3.7b



Source: National Health Service, 2013b; 2013c

AHPs' views about whether their role makes a difference

Another key finding from the NHS Staff Survey combines answers from a number of questions to give 'the percentage of staff agreeing that their role makes a difference to patients'. It finds that AHPs are noticeably more positive than other staff in this regard. Figures 3.7a and 3.7b show, for the period 2008 to 2013, the percentage of AHPs and of all staff who felt that their role made a difference to patients. The percentage of AHPs, healthcare scientists, and scientific and technical staff who felt that their role made a difference was higher than the all-staff average in every year, and was 3.2 percentage points higher in 2013. Practitioners from the individual professions also felt positively about this, excluding paramedics, who showed a decline from 2010. In 2010, 92.3 per cent of paramedics felt that their role made a difference to patients; this had declined to just 83.3 per cent by 2013 – 6.4 percentage points lower than all staff.

The future of the AHP workforce

While we have seen with the data available that the number of registered AHPs and those working in the NHS has increased, we also know that there are some challenges which may impact the future of the AHP workforce. The report *Workforce Risks and Opportunities: Allied health professionals* (Centre for Workforce Intelligence, 2011) notes a number of key risks:

- less money for training places
- availability and quality of supervised clinical placements
- freezing and downgrading of posts
- shortage of senior and specialist staff
- demand from multiple sectors
- demand from other countries.

Again, there are few data available to understand how these are impacting AHPs nationally, but it will be increasingly important to monitor how these challenges affect the workforce.

In 2013, Health Education England set out workforce plans for proposed education and training commissions for 2014/15. It proposed to 'broadly maintain the number of AHP commissions' (Health Education England, 2013, p. 7). While the plan is a modest increase in AHP training, Health Education England remarked that over-supply of AHPs may become a future concern. However, it noted that AHPs have an ability to work across sectors, and demand for AHPs may be linked with growth in patients with long-term conditions and more complex needs.

4

Effectiveness

Good-quality care should be based on relevant, rigorous evidence or nationally agreed best practice. However, effectiveness can be difficult to assess on a large scale, because of the need to measure both how effective a service/professional/intervention is at improving health benefits for patients, and how care is delivered in practice to the appropriate people at the right time. Moreover, seeing changes in outcomes, such as improved wellbeing in patients, takes time and can be difficult to measure directly. Often we rely on proxy measurements such as reduced hospital readmissions or people living in their own home. These general issues are especially true for AHPs in addition to particular challenges when trying to assess effectiveness in AHPs as a collective group.

First, AHPs are distinct professionals that have varied roles and work in a variety of settings, with many different outcomes. So, understandably, any research that shows the effectiveness of AHPs is normally specific to a professional group or a condition. Their work is not necessarily linked to specific outcome measures that they are solely or directly responsible for influencing (DH, 2008a), and they are often part of larger multidisciplinary teams.

Second, across AHP groups there is very little consistent nationwide information about either the volume or the quality of care provided. Therefore, data available to measure the effectiveness of AHPs are limited. Despite the lack of available national-level data, we do note that there are many studies which look at the effectiveness of individual services.

The visibility of AHP roles in guidelines for effective care is limited, although there are some good examples where AHP roles are explicitly referred to in guidance provided by the National Institute for Health and Care Excellence (NICE), for example on the management of stroke (NICE, 2010), hip fractures (NICE, 2012) and rheumatoid arthritis (NICE, 2013a).

So, for instance, the guidance on the management of rheumatoid arthritis (NICE, 2013a) states that people should have access to specialist physiotherapy, occupational therapy and podiatry to help them manage their arthritis. Similarly, the guidance on nutrition support in adults (NICE, 2006) states that: 'All acute hospital trusts should have a multidisciplinary nutrition support team which may include:... dietitians,... and other allied healthcare professionals (for example, speech and language therapists).'

One area where studies of AHP effectiveness has led to better data collection and a broader understanding of AHP contribution is stroke care. The NICE (2010) Stroke Quality Standard includes 11 quality statements designed to drive measurable quality improvements in stroke care and services. The Quality Standard highlights the importance of multidisciplinary teams in improving stroke care and AHPs are a key part of that. It states:

the core of the specialist rehabilitation team will include physiotherapy, occupational therapy, speech and language therapy, and psychology. Support and

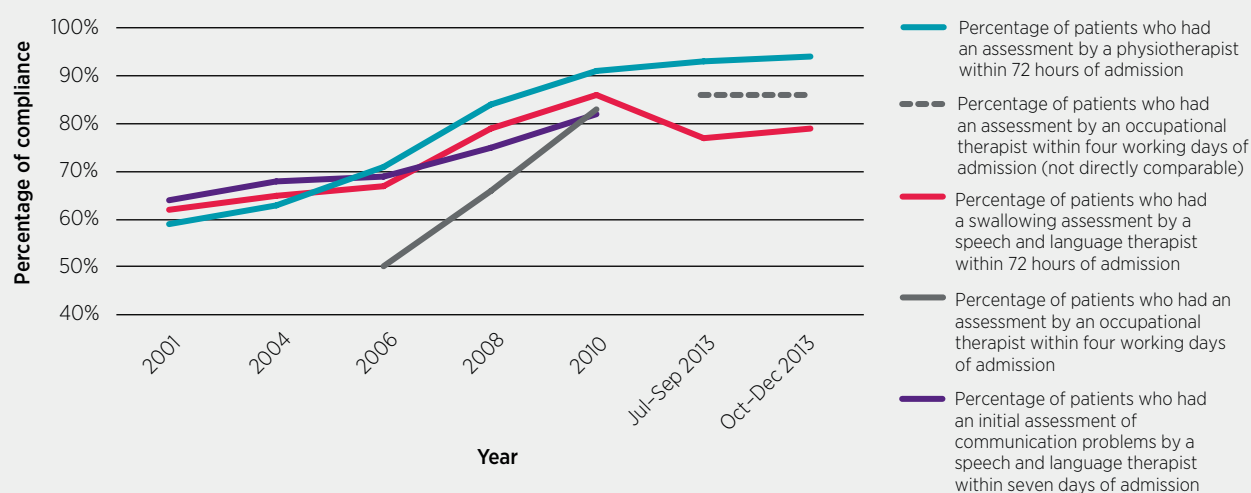
'The visibility of AHP roles in guidelines for effective care is limited'

input from social work, dietetics, pharmacy, orthotics and orthoptics should be available as required to address patients' needs. (NICE, 2010)

Adherence to this is measured in the Sentinel Stroke National Audit Programme conducted by the Royal College of Physicians. This audit took place in 2006, 2008 and 2010; since then the audit has changed and has reported quarterly since July 2013 (Royal College of Physicians, 2013).

Figure 4.1 illustrates how data from the stroke audit show improvements in the timeliness with which patients accessed AHPs from 2001 to 2013. Most of the measures showed improvements over time. The biggest change was seen for the percentage of stroke patients who had an occupational therapy assessment within four days of admission; this increased by 33 percentage points, from 50 per cent in 2006 to 83 per cent in 2010. Although the figures are not directly comparable, this increased to 86 per cent in July to September 2013 and October to December 2013. The only measure to show a reduction was the percentage of people who had a swallowing assessment by a speech and language therapist within 72 hours of admission; this fell from a peak of 86 per cent in 2010 to 79 per cent in October to December 2013. In October to December 2013, the percentage of compliance for all measures where data are available was above 79 per cent.

Figure 4.1: How the AHP contribution to stroke care has changed, 2001–2013



Source: Royal College of Physicians, 2007; 2014

Another example of national data collection that specifically includes AHPs is the inclusion of physiotherapists in the National Hip Fracture Database. Since early 2014, information has been collected on post-operative physiotherapy for patients with hip fractures (Chartered Society of Physiotherapy (CSP), 2014). While it is too early to include any outcomes in this report, this is an area where we will have data on AHP quality of care in the future.

A national audit of intermediate care (NHS Benchmarking Network, 2013) looked at care provision and commissioning, focusing on the provision of support for older people in 2013. Throughout the audit report, the contribution of various AHPs was noted, including occupational therapists, physiotherapists, speech and language therapists, podiatrists and dietitians. While there were references to AHPs, it was noted in the report that, currently, there are no ways of collecting data to see the extent to which relevant AHPs are involved.

5

Access

There are many ways in which patients access AHPs: via self-referrals, direct referrals from secondary care, GP referrals and referrals from a range of other professionals. There are minimal data available to capture all these methods, but one area where we can look at AHP activity is outpatient appointments coded as AHP episodes. This has the limitation that it only identifies activity in acute hospitals. However, using Hospital Episode Statistics outpatient data, we can also look at the characteristics of these appointments. The outpatient dataset is made up of individual records for all outpatient attendances occurring in England. From 2006/07 onwards, AHP was included as a consultant specialty code. However, while this code was introduced in 2006/07, it is unlikely that it was being used fully in the first few years, so caution must be applied to interpreting these results. These data are also reliant on the hospitals' accuracy of applying the appropriate coding.

In 2012/13, there were 94.1 million outpatient appointments in England, with 30.1 per cent recorded as first attendances. AHP appointments were one of the largest consultant specialties, with 7.5 million episodes (9.9 per cent of all appointments) (HSCIC, 2013c).

'The largest AHP specialty by far for those aged 65 was physiotherapy'

Figure 5.1 shows how the age and sex of attendees varied in 2012/13 for all AHP outpatient appointments. Overall, 56.0 per cent of the appointments were attended by females and 43.5 per cent by males. We see peaks at 0 years, five years and 15 years, and then a general increasing trend of appointments to a maximum at 65 years for both sexes. For those aged 0, the three most common specialties were physiotherapy, dietetics and orthoptics; combined, these accounted for 58.7 per cent of appointments. For those aged five, 50.0 per cent of the appointments were recorded as either orthoptics or ophthalmology. We know that screening for visual impairment in children should be offered between the ages of four and five years (UK National Screening Committee, 2013) and this peak corresponds to the appropriate age group. There is no clear explanation for the peak seen at age 15; however, the largest specialty (51.2 per cent) was physiotherapy. The largest specialty by far (45.0 per cent of appointments) for those aged 65 was physiotherapy. Although there is no indication in the data, it is likely that this peak was due to the assessment and prevention of falls in older people, which focuses on those aged 65 and over (NICE, 2013b), or recovery from a fall.

Figure 5.2 shows the distribution of the number of appointments for patients in 2012/13 (we excluded those with more than 30 appointments). Data for the figure include all appointments, both first attendances and follow-ups. Forty-five per cent of patients had only one appointment in the year, while a further 44 per cent had between two and five appointments. As we know, many AHPs work outside the hospital setting and it is important to consider if these data represent the full patient pathway. For some groups of professionals, such as radiographers, these data may be reflective of the fact that they work primarily in NHS hospitals and it is appropriate that they only see a patient for one appointment. But for others, such

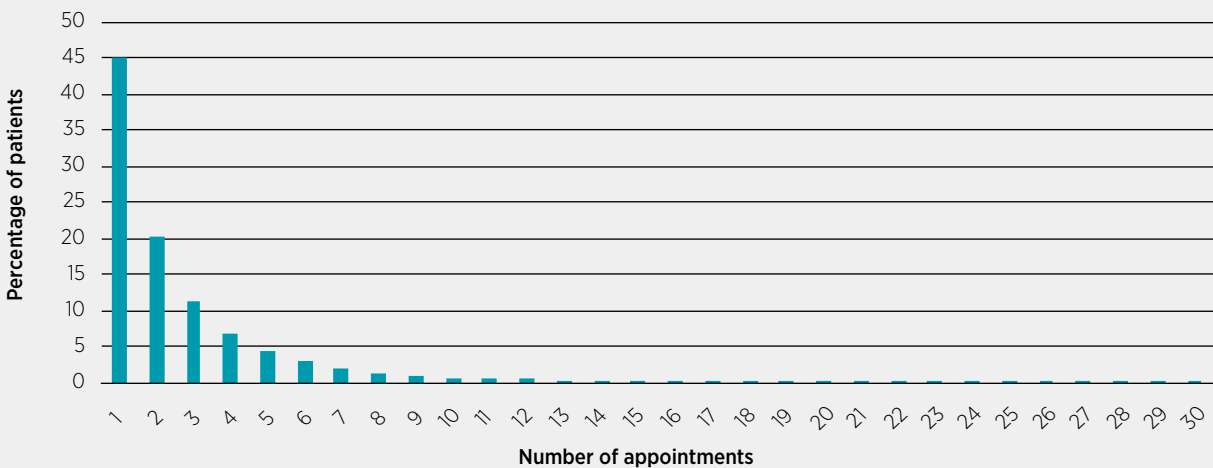
as physiotherapists and podiatrists, a lot of care takes place outside of the hospital setting and it would also be unlikely that people have only one appointment with these professionals.

Figure 5.1: Distribution of AHP outpatient episodes by age and sex, 2012/13



Source: Analysis of Hospital Episode Statistics data: Health & Social Care Information Centre, 2014b

Figure 5.2: Distribution of the number of appointments for patients, 2012/13



Source: Analysis of Hospital Episode Statistics data: Health & Social Care Information Centre, 2014b

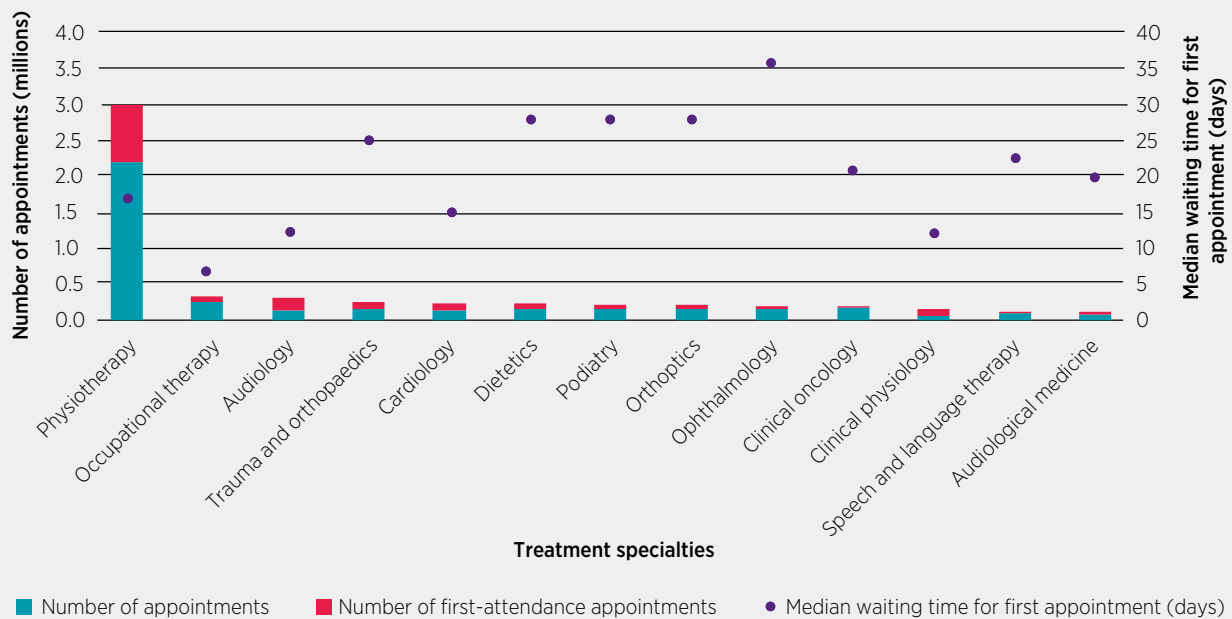
Although the number of AHP episodes has increased over the years, this is most likely due to increased use of the AHP code so it is difficult to estimate changes in total activity over time. Despite the caveats in these data, for the records we do have, we can estimate how long people waited for their first outpatient appointment. Across all professions, the average recorded waiting time in 2012 was 19 days. It is worth noting that the national target for referral to treatment time is 18 weeks – waiting times for AHP appointments were well below this in 2012, with a median waiting time of just under three weeks.

From 2015, AHPs will be included in nationally available referral to treatment time data via the Community Information Data Set and the Commissioning Data Set. These datasets will provide comparable, patient-level information about how

patients interact with NHS-funded services beyond the hospital setting. For AHPs this will give a more accurate picture of how long people wait for these appointments, how many people are waiting and how this changes over time. In the future this will also be included in the Mental Health Minimum Data Set (MHMDS) to ensure that AHP activity in mental health settings is captured along with acute and community settings (Information Standards Board for Health and Social Care, 2013).

Figure 5.3 shows the total number of appointments, the number of first attendances and the median waiting time for the 12 largest treatment specialties of AHP appointments in 2012. Here we are looking at all outpatient appointments where the main consultant speciality was an ‘allied health professional’. As well as the main specialty, we can also look at the treatment specialties of these appointments; these describe the specialised service within which the patient was treated. Treatment specialties can include more general services such as surgery, rehabilitation, neurology and some specific to AHPs, such as physiotherapy and occupational therapy. The largest treatment specialty for AHP appointments was physiotherapy, which had a median waiting time of 17 days – lower than the AHP average. The longest waiting time was for ophthalmology appointments, at 36 days.

Figure 5.3: Appointments and waiting times for the main AHP treatment specialties, 2012



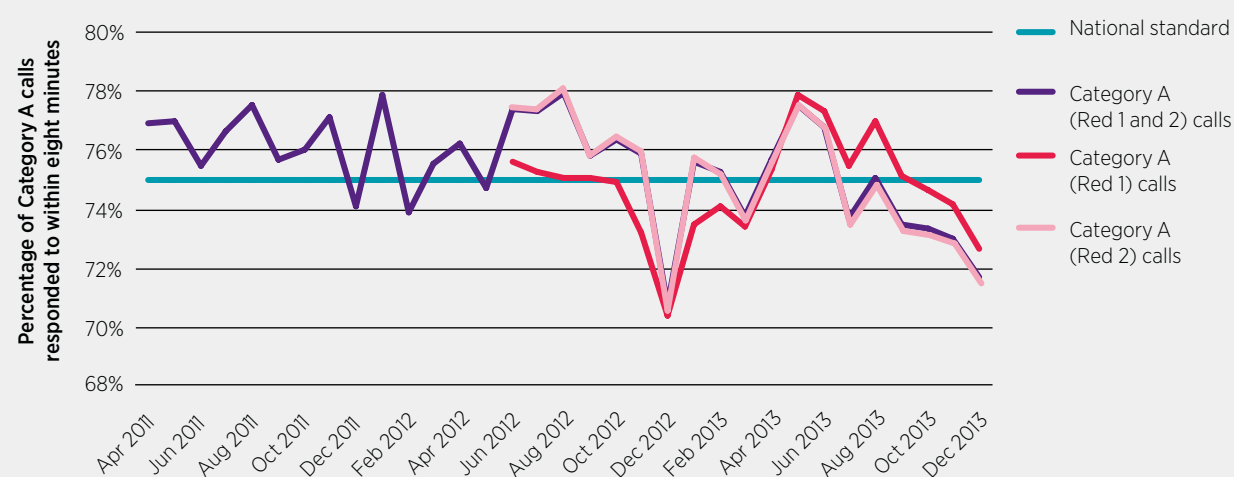
Source: Analysis of Hospital Episode Statistics data: Health & Social Care Information Centre, 2014b

Paramedics

Paramedics are one professional group where there is much more information available at the national level, particularly in relation to indicators around access. NHS England publishes monthly data on ambulance quality indicators (NHS England, 2014). While ambulance data cover a range of health professionals, paramedics are a core part of every ambulance team.

While there are many other indicators in this ambulance dataset, we have chosen to focus on response times as an example. Figure 5.4 shows how ambulance response times have varied over time. Category A (Red 1 and Red 2) ambulance calls are those that are classed as life-threatening and the national standard sets out that 75 per cent of these calls should receive a response within eight minutes (NHS Choices, 2014a). Between April 2011 and December 2013 there were 10 months where this standard was breached nationally, which translates into a breach in one month out of three. The frequency of breaches also increased year-on-year. In 2011/12 and 2012/13, the breaches mainly occurred during the December to March period; however, in 2013/14 the breaches first occurred during July 2013 (74 per cent), after which the standard recovered slightly in August 2013 (75 per cent), before being breached again in September 2013 and continuing to decrease to just under 72 per cent in December 2013. It is not clear what is causing these breaches and further investigation would be needed to understand this. However, some analyses suggest that the number of calls may be a contributing factor (QualityWatch, 2014b).

Figure 5.4: Ambulance response times, April 2011 to December 2013



Source: NHS England, 2014

Other data sources

There have been some reports of changes to specific services affecting waiting times to access AHP services. In 2011, the CSP commissioned a survey to ask the most senior physiotherapy staff to provide comment on waiting times for outpatient appointments across the UK (CSP, 2011). In total, 109 physiotherapy managers participated in the research, which covered 401 outpatient departments.

The main findings were:

- In 2011, just under 40,000 people were on the waiting list for an outpatient physiotherapy appointment (an average of 523 per department), compared with just under 120,000 in 2010 (an average of 813 per department).
- The longest waiting time reported by the majority of respondents in 2011 was six to eight weeks, compared with seven weeks in 2010.

- The shortest maximum waiting time reported in 2011 was less than one week, compared with two weeks in 2010.
- The longest waiting time reported in 2011 was 30–40 weeks, compared with 18 weeks in 2010.

Respondents were also asked to give their thoughts on how the 2011 waiting times compared with those in 2010 and the results were:

- 32 per cent reported that waiting times had increased
- 38 per cent reported that waiting times had decreased
- 30 per cent reported no change in the length of waiting time.

Although caution must be exercised in interpreting these data, as only 72 of the 109 survey respondents answered this question, the survey indicated that, overall, physiotherapy managers felt that access was either staying the same or improving: waiting lists were shorter, the shortest waiting time had improved and the majority (68 per cent) felt that, compared with 2010, waiting times had decreased or stayed the same. There was, however, a large increase in the longest waiting time, which increased from 18 weeks in 2010 to 30–40 in 2011.

In relation to speech and language therapies, a review of services for children and young people (aged 0–19) with speech, language and communication needs (Bercow, 2008) found that many parents/carers felt that there were 'lengthy waiting times and problems experienced when trying to access speech and language therapy through Local Authorities (LAs) and NHS/Health Authorities' (p. 102), with many accessing these services privately. This review included a survey in 2007 of 2,000 families which found that:

- 21 per cent felt that it took too long to see a therapist
- 26 per cent felt they hadn't received enough therapy
- 21 per cent noted that services were not available for all children due to age, location or type of disability
- 27 per cent felt that waiting lists were too long.

Since this review, a number of initiatives have taken place to address these issues and reduce the variability of service provision across England. One such initiative involved talking to 105 local authority/primary care trust pairings (out of 152) between January 2010 and December 2011 to understand what was happening to speech and language therapy services for children. The report on the initiative – *Two Years On: Final report of the Communication Champion for Children* (Gross, 2011) – particularly highlighted integrated services and joint commissioning as two of the success factors, but noted that issues with variation still remained.

6

Safety

Safety is one of the most challenging aspects of quality to measure (QualityWatch, 2013). Beyond the difficulties of AHP data collection generally, appropriately measuring safety comes with its own additional challenges. A recent framework identified five dimensions of safety that organisations could consider:

- past harm
- reliability
- sensitivity to operations
- anticipation and preparedness
- integration and learning (Vincent and others, 2013).

The promotion of safety is usually something that spans a whole organisation or system, and is not focused on selected staff groups. This means there are no safety measures specific to AHPs.

Existing measures of safety may also be too broad to capture specific safety issues which could be associated with AHP care. Moreover, many of the professions work outside settings where incident reporting is focused, such as surgery or harm as a result of medication errors.

There is clearly an expectation that AHPs are part of this broader picture of safety, yet there is little specific information about safety issues in AHP care. All AHPs must abide by professional standards and regulations (DH, 2011; HCPC, 2013a), which include standards covering safety. However, we have not been able to identify specific information on adherence to, or lapses in, safety standards specifically in relation to AHPs.

7

Person-centred care and experience

The absence of routine markers of patients' views on their experience of care delivered by AHPs makes it difficult to assess this aspect of quality and whether it is changing. There are some reports of access and workforce problems, typically in terms of posts being cut or people waiting longer for services. However, these reports are not widespread.

29%
Percentage of respondents to Stroke Association survey wanting more physiotherapy support

Some charities have conducted independent surveys exploring questions around access to AHPs. For example, a survey of 10,530 people with multiple sclerosis (MS) in the UK conducted by the MS Society showed that, in 2012, 70 per cent of respondents felt that their need to see a physiotherapist had been met (Dorning and others, 2013). This was similar to other professionals studied in that survey (neurologists and nurses).

Similarly, the Stroke Association conducted a survey of over 2,200 stroke survivors and carers in 2011. When asked whether they felt they received enough support from NHS services and to indicate their biggest priority:

- 29 per cent of respondents felt that they needed more support from physiotherapists
- 6 per cent felt that they needed more support from speech therapists
- 4 per cent felt that they needed more support from occupational therapists (Stroke Association, 2012).

This suggests that the majority of respondents were getting the support they needed from key AHPs, with access to physiotherapy being the most pressing concern.

8

Equity

Can everyone access AHPs? Again, with limited data it is hard to identify whether AHP care is provided fully to all social groups according to their needs. It is difficult to know, for example, whether younger people are able to access podiatry services as easily as older people when they need to.

Many of the allied health professions can be accessed privately, where a patient is able to pay for services or care themselves. However, there are no data collected to understand when, where and how often people are paying privately; and whether paying for a service affects the quality of service and care that people receive.

Many of the professional bodies that represent the allied health professions have guidance on accessing those professionals. For example, the College of Occupational Therapists has guidance on accessing an occupational therapist privately and recommends that people always ensure that the professional is registered with the HCPC (British Association of Occupational Therapists and College of Occupational Therapists, 2014). NHS Choices also advises that if services are not available to someone on the NHS, they should access them privately (NHS Choices, 2014b). For example, podiatry services are commissioned differently by each local area, which means that the NHS-funded services that each clinical commissioning group offers vary and may not be available in some areas.

9

Developing information about AHPs

As we have seen, the availability of routine, national-level data with which to look at the quality of care and services delivered by AHPs is very limited. AHPs are a group of care professionals – operating in different settings – but they all have in common the fact that they contribute to longer-term care pathways. At present, their work is often hidden due to a lack of data and information.

The information available and the analysis undertaken in this report do not reveal any major problems so far, although there are some signs of concerns. On the positive side:

- the workforce is increasing
- AHPs generally feel that they make a difference to patients and are happy with the quality of care they are able to deliver
- patients feel that they can access the AHPs they need.

However, within this, we see some AHPs, such as paramedics, responding negatively to many of the questions in the NHS Staff Survey.

The report has shown that there is a disparity between the growth of registered AHPs and those working in the NHS. It appears that the number of AHPs working in non-AHP settings has grown. While there are limitations in comparing the data, it is important to note that this provides further challenges to monitoring the quality of care.

We also note that while, so far, we have not seen many signs of strain, issues affecting the AHP workforce – such as the number of education places, reduced commissioning and downgrading – will not be visible until further down the line. This is a particularly challenging time in health and social care and, without reliable data, it is hard to see how AHPs will respond and how care might be affected. We have also seen how the collection of data on AHP care, such as in the stroke audit, can drive improvements.

Some work has already noted the lack of data available to measure the quality of AHP care. For example, in 2008, the Department of Health published *Framing the Contribution of Allied Health Professionals: Delivering high-quality healthcare* (DH, 2008a) to support *High Quality Care for All: NHS next stage review final report* (DH, 2008b). This focuses on key aspects to improving the quality of care that AHPs deliver:

- mandating the collection of referral to treatment data for AHP services
- promoting the benefits of self-referral to physiotherapy services and encouraging the expansion of this to other AHPs.

In 2010, the Department of Health introduced the voluntary collection of ‘AHP referral to treatment time’, with mandatory collection from April 2011. This has been reported locally since April 2012 (HSCIC, 2013b; 2013c). However, the current

timescales show that, due to a lack of funding, the data will not be centrally available until 2014/15.

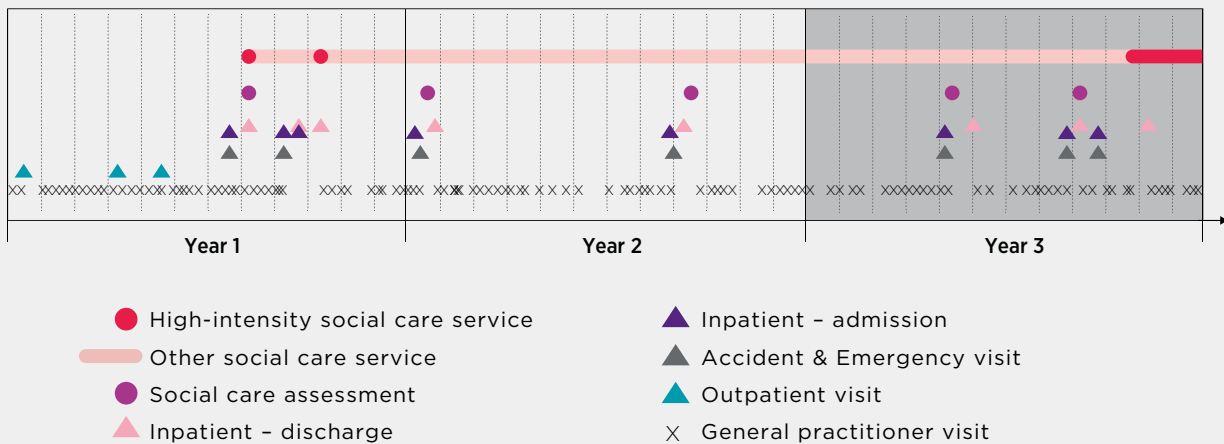
The launch of the information strategy, *The Power of Information* (DH, 2012), by the NHS in May 2012 has also pushed for improved data collection. This strategy is encouraging AHPs to improve how information is collected and used. This was highlighted in a guidance document by the National Clinical Lead for AHPs, Yvonne Pettigrew. *Making it Happen – The Power of Information: Putting all of us in control of the health and care information we need* (Pettigrew, 2012) is an implementation guide for AHPs and highlights the need for them to ‘optimise the full potential of informatics to improve the services [they] deliver’ (p. 3). The guide also includes recommendations for AHPs to improve information systems so that information can drive change, which should support the delivery of high-quality, cost-effective health and care services.

As described earlier, one area where recommendations for good-quality care have been linked to data on AHP activity is stroke care. Collection of the stroke audit data has not only highlighted what AHPs contribute, but also shown the clear improvement there has been in this area over the last few years. Similarly, the National Hip Fracture Database, from early 2014, started collecting data on post-operative physiotherapy for patients with hip fracture (CSP, 2014); while it is too early to include results in this report, this will be a new way to capture national data on the quality of physiotherapy care. There are many other areas and conditions where a similar data collection could document the quality of AHP care, such as other long-term neurological conditions, older people and diabetes.

Data like these are still based in the acute sector. However, for many AHPs, their work takes place in many settings, spanning health and social care, acute and community settings, and settings outside of the NHS. Many AHPs are already collecting potentially rich data as part of their day-to-day jobs and much could be done to include this in a wider information system. The government’s information strategy has ambitions to integrate information about health and social care, and for each person’s NHS Number to be used consistently across the whole system. Having linked health and social care data would increase our understanding of the quality of care that AHPs provide.

Figure 9.1 shows a ‘Theogram’, an event timeline for health and social care usage for one person over three years. This is one illustration of what linked data looks like. In an ideal world, we might imagine that specific inputs delivered by AHPs could be added at the relevant stages in this pathway. So, for example, a dataset that included a description of individual appointments might include basic information on the patients, the treatment, the time and so on. Such a basic record could easily be designed in a way that enables integration with other information systems. Such data could be used to understand the impact that access to an AHP has. Using stroke care as an example, we could compare the outcomes (such as Accident & Emergency (A&E) use or social care use after discharge) for people who saw a physiotherapist within 72 hours of admission and whether access to physiotherapy led to improved outcomes.

Figure 9.1: 'Theogram' showing an event timeline for health and social care use for one person over a three-year period



'The challenge will be to collect consistent and comparable information'

We recognise that the development of these types of information can take a long time, particularly if they are built as a comprehensive system from scratch. However, there are now very few aspects of our daily lives where some form of electronic recording does not take place; and the care delivered by a healthcare professional is no exception. Many of these systems are already operating. The challenge here will be to collect consistent and comparable linked information from these different systems to construct the type of patient pathway shown above. For retrospective analysis of existing datasets, a number of studies have shown that such data linkage is possible (see below). The biggest challenge is the integration of operational information systems to provide real-time (or near real-time) information.

Some examples of where this retrospective approach to data linkage has already been used are in ambulance services, where information about transported patients can be linked to outcomes in hospital. Published studies have so far tended to focus on the robustness of linkage (Downing and others, 2005; Mears and others, 2010; Patient Pathways, 2010). Other programmes currently in progress aim to describe subsequent hospital use for patients transported by ambulance crews (Clark, 2014) and to use characteristics of the patient and their emergency to predict outcome (PhOEBE, 2011). In Australia, this approach has been used to study the whole-system impact of opening an additional emergency department (Crilly and others, 2013).

Such pragmatic approaches are more likely to deliver useful outcomes in the short term provided that clinical staff are supported to deal, appropriately, with the need to protect the confidentiality of information and are given the specialist tools and training to record meaningful data and to be able to look across datasets.

10

Conclusion and recommendations

At the start of this analysis, we had hoped to document the change in the quality of AHP care and, in particular, how changes in the health system were impacting on this. However, we found that there were very limited information and data to do this. Instead, we have highlighted the need to develop information systems that adequately capture consistent and comparable information on all aspects of the quality of AHP care.

While some work has already started to improve data collection on the quality of AHP care, the future agenda needs to include:

- **Recognition of AHP activity in the implementation of community information systems.**

As the development of the Community Information Data Set and the Commissioning Data Set continues, it is important that AHPs are appropriately included, and opportunities to capture activity are identified and implemented. Although data on referral to treatment time is being collected, other aspects of care also need to be captured. It is equally important that AHPs are appropriately trained to collect meaningful and consistent data. This will include having access to technology to record the data, and the training and support needed for such systems.

- **The development of ways to link basic administrative information with care records.**

As the work of AHPs involves many settings and scenarios, it is important that data from individual professional encounters are not kept in isolated datasets but can be linked with other patient information in common care records. We have seen an example of how linked datasets can lead to improvements of care, and continuation of this work will build a richer and more accurate picture of the care and services that AHPs provide.

- **The development of ways to use information to quality-assure the care that AHPs deliver.**

Alongside better information on AHP activities, it is also important to ensure that this translates into improved practice, for example ensuring that benchmarking is used and areas of best practice are highlighted.

- **Continued development of AHP research.**

This includes understanding the quality of AHP care in two ways:

- by looking at the longer-term pathways of care and finding/understanding where and why variation exists
- by conducting specific studies that focus on shorter-term outcomes, in terms of physical health, social/psychological issues or activities of daily living. This could be specific to a profession, a condition or both.

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Appendix: Allied health professionals and the work they do

| Professional | What they do |
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| Chiropodists/ podiatrists | <ul style="list-style-type: none"> • Chiropodists/podiatrists provide essential assessment, evaluation and treatment of foot problems for a wide range of patients with a variety of conditions, both long-term and acute. • Many of these fall into high-risk categories such as patients with diabetes, cerebral palsy, peripheral arterial disease and peripheral nerve damage where podiatric care is of vital importance. • Many podiatrists have become further specialised into the area of either biomechanics or surgery. Biomechanics is often associated with treating sports-related injuries, but spans across a wide range of conditions, including children and older people. Podiatric surgeons offer surgical interventions in all aspects of foot health management. • Podiatrists work in both the community and acute settings, and while many are employees of the NHS, many now provide healthcare services in the private sector. <p>You can find out more from the College of Podiatry: www.scpod.org .</p> |
| Dietitians | <ul style="list-style-type: none"> • Dietitians assess, diagnose and treat diet and nutrition problems at an individual and a wider public health level. • Uniquely, they use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. • With a commitment to enhancing public health, the dietetic workforce is essential to making change happen in hospitals, care homes and the wider community. <p>You can find out more from the Association of UK Dietitians: www.bda.uk.com .</p> |
| Dramatherapists and art and music therapists | <ul style="list-style-type: none"> • Dramatherapists and art and music therapists work with all age groups and utilise both the psychological and social potentials of the arts to support people with a wide range of physical, communication and mental health issues. • They work in community, hospital, education and early years' settings and, as such, are well placed to integrate pathways from acute services into the community, thus creating wide-ranging efficiency savings. • Looking at the wider public health agenda, they contribute to the overall wellbeing of communities and reduce the social stigma that often accompanies mental health issues. <p>You can find out more from the British Association of Art Therapists: www.baat.org, the British Association of Dramatherapists: www.badth.org.uk and the British Association for Music Therapy: www.bamt.org .</p> |
| Occupational therapists | <ul style="list-style-type: none"> • Occupational therapists work with people of all ages with a wide range of problems resulting from physical, mental, social or developmental difficulties. • They support people with a range of interventions to enable them to return to, or optimise participation in, all the things that people do; for example, caring for themselves and others, working, learning, playing and interacting with others. • Being deprived of, or having limited access to, any or all of these occupations can affect physical and psychological health. • Hence, occupational therapists positively impact upon the wellbeing and rehabilitation of patients in most care pathways and in the broader public health and social care environment. <p>You can find out more from the British Association of Occupational Therapists and College of Occupational Therapists: www.cot.co.uk .</p> |

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| <p>Orthoptists</p> | <ul style="list-style-type: none"> • Orthoptists help premature infants with retinopathy of prematurity, children with reduced vision due to squint, and adults and children with eye movement defects due to diabetes, hypertension, endocrine dysfunction, cancer, trauma and stroke. • Extended scope orthoptic practitioners now work in high-volume ophthalmic specialties such as glaucoma, cataract and age-related macular degeneration. • Orthoptists undertake the diagnostic and therapeutic roles formerly provided solely by medical staff, leading to the potential for major financial savings while continuing to deliver the highest-quality patient care. • They work in acute hospital and community settings in health and education, often as part of a multidisciplinary medical, nursing and AHP team. <p>You can out more from the British and Irish Orthoptic Society: www.orthoptics.org.uk/ .</p> |
| <p>Paramedics</p> | <ul style="list-style-type: none"> • Paramedics are the senior ambulance service healthcare professionals at an accident or a medical emergency. • Often working by themselves, they are responsible for assessing the patient’s condition and then giving essential treatment. • They use high-tech equipment such as defibrillators, spinal and traction splints and intravenous drips, as well as administering oxygen and drugs. <p>You can find out more from the College of Paramedics: www.collegeofparamedics.co.uk .</p> |
| <p>Physiotherapists</p> | <ul style="list-style-type: none"> • Physiotherapists use physical approaches to promote, maintain and restore physical, psychological and social wellbeing, working through partnership and negotiation with individuals to optimise their functional ability and potential. • They address problems of impairment, activity and participation and manage recovering, stable and deteriorating conditions – particularly those associated with the neuromuscular, musculoskeletal, cardiovascular and respiratory systems – through advice, treatment, rehabilitation, health promotion and supporting behavioural change. • They use manual therapy, therapeutic exercise, the application of electro-physical modalities and other physical approaches in response to individual need. • They work across sectors and settings, including acute, community and workplace settings, and with a large number of population and patient groups, including children, working-age people and older people, at all points of an individual’s healthcare journey. <p>You can find out more from the Chartered Society of Physiotherapy: www.csp.org.uk .</p> |
| <p>Prosthetists and orthotists</p> | <p>Prosthetists</p> <ul style="list-style-type: none"> • Prosthetists are autonomous registered practitioners who provide gait analysis and engineering solutions to patients with limb loss. • They are extensively trained at undergraduate level in mechanics, biomechanics and material science, along with anatomy, physiology and pathophysiology. • Their qualifications make them competent to design and provide prostheses that replicate the structural or functional characteristics of the patient’s absent limb. • They are also qualified to modify CE-marked prostheses or componentry, taking responsibility for the impact of any changes (CE-marked devices being those that comply with European regulations). • They treat patients with congenital loss as well as loss due to diabetes, reduced vascularity, infection and trauma. Military personnel are forming an increasing part of their caseload. • While they are autonomous practitioners, they usually work closely with physiotherapists and OTs as part of multidisciplinary amputee rehabilitation teams. <p>Orthotists</p> <ul style="list-style-type: none"> • Orthotists are autonomous registered practitioners who provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. • They are extensively trained at undergraduate level in mechanics, biomechanics and material science, along with anatomy, physiology and pathophysiology. |

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| | <ul style="list-style-type: none"> • Their qualifications make them competent to design and provide orthoses that modify the structural or functional characteristics of the patient’s neuromuscular and skeletal systems, enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent ulcers and facilitate the healing of ulcers. • They are also qualified to modify CE-marked orthoses or componentry, taking responsibility for the impact of any changes. • They treat patients with a wide range of conditions, including diabetes, arthritis, cerebral palsy, stroke, spina bifida, scoliosis, musculoskeletal conditions, sports injuries and trauma. • While they often work as autonomous practitioners, they increasingly often form part of multidisciplinary teams such as within the diabetic foot team or neurorehabilitation team. <p>You can find out more from the British Association of Prosthetists and Orthotists: www.bapo.com .</p> |
| Radiographers | <p>Diagnostic radiographers</p> <ul style="list-style-type: none"> • Diagnostic radiographers employ a range of techniques to produce high-quality images in order to diagnose an injury or disease. • They are responsible for providing safe and accurate imaging examinations and increasingly also the resultant report. • Diagnostic imaging is a component of the majority of care pathways. • Radiographers are also key team members in breast screening and the ultrasound monitoring of pregnancy. <p>Therapeutic radiographers</p> <ul style="list-style-type: none"> • Therapeutic radiographers play a vital role in the treatment of cancer. • They are also responsible as the only health professionals qualified to plan and deliver radiotherapy. Radiotherapy is used either on its own or in combination with surgery and/or chemotherapy. • Therapeutic radiographers manage the patient pathway through the many radiotherapy processes, providing care and support for patients throughout their radiotherapy treatment. <p>You can find out more from the Society of Radiographers: www.sor.org .</p> |
| Speech and language therapists | <ul style="list-style-type: none"> • Speech and language therapists work with children and adults to help them overcome or adapt to a vast array of disorders of speech, language, communication and swallowing. • This includes: <ul style="list-style-type: none"> - helping young children to access education - working with young offenders to enable them to access programmes designed to reduce re-offending - reducing life-threatening swallowing problems in the early days after stroke - providing essential support to adults with a range of acquired neurological communication difficulties, to help them to return to work, and their roles in their family and society. • Appropriate early intervention can lead to considerable long-term financial savings. • Whether in acute hospital or community settings, mainstream or special schools, or increasingly in secure estate settings such as young offender institutions, speech and language therapists make a huge difference to individuals and their families. <p>You can find out more from the Royal College of Speech & Language Therapists: www.rcslt.org .</p> |

Source: Allied Health Professions Federation (2005)

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