Department of Health

Practitioners with Special Interests

Implementing a scheme for Allied Health Professionals with Special Interests

November 2003
**Document Purpose**
Best Practice Guidance

**ROCR Ref:**
Gateway Ref: 2141

**Title**
Allied Health Professionals with Special Interests

**Author**
DH/Access and Choice/Primary

**Publication date**
00 Nov 2003

**Target Audience**
PCT CE's, Care Trusts CE's, Medical Directors, PCT PEC Chairs, Directors of HR, Allied Health Professionals

**Description**
This document provides PCTs and other NHS organisations with guidance, and some case studies, on how to develop the roles of allied health professionals with special interests, so as to expand the range of services which can be provided in primary care and community settings.

**Cross Ref**
Implementing a scheme for General Practitioners with Special Interests (April 2002), Implementing a scheme for Nurses with Special Interests in Primary Care (April 2003).

**Superseded Doc**
N/A

**Action required**
N/A

**Timing**
N/A

**Contact Details**
Gareth James
WRS, Access and Choice – Primary Care
Rm 4N34D, Department of Health
Quarry House, Quarry Hill
Leeds LS2 7UE
(0113) 254 5258
gareth.james@doh.gsi.gov.uk

**For recipient use**
Foreword

Meeting the Challenge set out the Government’s plans for developing and supporting the Allied Health Professions (AHPs) to deliver the NHS Plan. It emphasised the importance of ensuring that the work of AHPs was built around the needs of patients rather than around traditional professional roles. Central to this is the development of the role of AHPs with Special Interests, in primary care and community settings.

The work of GPs and nurses with special interests undertaking secondary care outside of hospitals with the appropriate support from the acute sector has demonstrated the benefits which can be derived from the expansion of primary care services, for patients and staff alike. AHPs, who already work extensively in the community, have the potential to contribute greatly to this expansion as individual practitioners and as part of a multi-professional team. PCTs across the country are already developing innovative care pathways which permit the patient to receive outpatient appointments and follow-ups outside of hospital, or which improve primary care access to hospital-based services such as radiography. These initiatives are necessarily developed at a local level, as it is only then that the service can be sufficiently flexible and well informed to make the best of local resources, and meet local need.

This document is intended to offer employers and health professionals useful information on the key issues which need to be managed in developing the role of the health professions in primary care services. It includes practical advice and a range of examples of service redesign. This guidance has been produced in consultation with a working group of health professionals, royal colleges, and NHS managers, who have given generously of their time and professional expertise to contribute to what I hope will prove a useful starting point for the improvement of services.

David Colin-Thomé
National Clinical Director for Primary Care

---

The professions which make up the Allied Health Professions have always understood the broader context of service provision across health and social care whilst understanding and appreciating the needs and values of service users. This document demonstrates the innovation of these service providers who have moved services forward by developing with others excellent clinical services. They are driving forward a new network of health and social care services not dependent on professional or organisational boundaries.

Their aim has always been to provide high quality, effective and integrated patient care which meets the health needs of their local communities. In doing this they have worked hard to develop the clinical, intellectual and personal skills of both professionally qualified staff and the support workers who are an essential part of the team.

This document demonstrates that these professions lead the way in working across the primary and secondary care interface, extend capacity and constantly raise the standard of clinical care. Their creative approach and team work is celebrated in the innovative approaches they have taken, I hope it will be a helpful guide for those just beginning to plan services in new ways and above all to be a helpful guide to improving patient care.

Kay East
Chief Health Professions Officer

Implementing a scheme for Allied Health Professionals with Special Interests
Introduction

Providing a wider range of services in primary care can bring real benefits to patients. Care can be accessed in convenient, community-based locations, and waiting times for an appointment in a community setting are often shorter than for a hospital appointment.

In 2002 guidance was produced on developing GPs with Special Interests\(^2\) to encourage PCTs to bridge the interface between hospitals and primary care and to increase the range of secondary care provided in the community. In recognition of the importance of multi-professional teamwork this guide describes how AHPs with a Special Interest (AH PwSI) i.e. with additional expertise, or working in innovative or enhanced ways, can be developed by PCTs to improve patient care and increase local primary care capacity. PCTs, as commissioners and providers of services will wish to consider the additional value AH Ps can bring to help meet the needs of patients.

This publication should be read in conjunction with the Modernisation Agency’s guide Practitioners with a Special Interest: A Step by Step Guide to setting up a General Practitioner with a Special Interest (GPwSI) Service, available at www.natpact.nhs.uk/special_interests

Allied Health professionals:

- Art Therapists
- Chiropodists/Podiatrists
- Diagnostic radiographers
- Dietitians
- Drama Therapists
- Music Therapists
- Occupational Therapists
- Orthoptists
- Paramedics
- Physiotherapists
- Prosthetists and Orthotists
- Speech and Language Therapists
- Therapeutic Radiographers

\(^2\) Implementing a scheme for General Practitioners with Special Interests (Department of Health and Royal College of General Practitioners, April 2002) www.doh.gov.uk/pricare/gp-specialists/gpwsiframe work.pdf
What is an Allied Health Professional with a Special Interest?

Allied Health Professionals are a cornerstone of the NHS, providing treatment and patient-centred care across the whole range of health and social services. Meeting the Challenge set out in detail the role of AH Ps in delivering the NHS Plan, through:

- providing faster, more accessible care;
- improving care for older people, and for those with cancer, heart disease or mental illness;
- developing the skills needed within a multiprofessional team approach which supports patients.
- driving through protocol-based care, care which is centred on the skills needed to support patients, and not on traditional professional roles;
- rehabilitation and intermediate care – joining up health and social care.

AH Ps are by definition, healthcare professionals with a focus on a particular specialty. However, in this document, AH P with a special interest (AH PwSI) is used to denote an AH P working in an expanded role within a primary care or community setting, the term maintaining continuity with GPs and Nurses with special interests who undertake outpatient care in the community. AH PwSI does not relate to a specific grade or specialty and could range from quite junior staff to AH P Consultants and extended scope practitioners. The key to AH PwSI is that these posts are driven by the need to redesign services in order to improve access for patients and to improve the service they receive.

AH PwSIs demonstrate many of the Ten Key Roles for Allied Health Professions which were launched in August 2003. These roles demonstrate the vision for Allied Health Professions in modernising the NHS and improving services for patients.
Ten Key roles for Allied Health Professionals

• To be a first point of contact for patient care, including single assessment.

• To diagnose, request and assess diagnostic tests, and prescribe, working with protocols where appropriate.

• To discharge and/or refer patients to other services, working with protocols where appropriate.

• To train and develop, teach and mentor, educate and inform Allied Health Professionals, other health and care professionals, students, patients and carers, including the provision of consultancy support to other roles and services in respect of patient independence and functioning.

• To develop extended clinical and practitioner roles which cross professional and organisational boundaries.

• To manage and lead teams, projects, services and case loads, providing clinical leadership.

• To develop and apply the best available research evidence and evaluative thinking in all areas of practice.

• To play a central role in the promotion of health and well being.

• To take an active role in strategic planning and policy development for local organisations and services.

• To extend and improve collaboration with other professions and services, including shared working practices and tools.
What does a PCT or Trust need to do?

The experiences of Primary Care organisations which have already undertaken service redesign suggest that a range of organisational factors need to be recognised in planning and developing the expansion of services utilising practitioners with special interests.

Assessing need, planning the service

Designing AHPwSIs is all about encouraging and supporting local practitioners to develop innovative solutions to service problems.

An essential tool to assist in the development of an AHP PwSI service is the NatPaCT guide Practitioners with special interests. A step by step guide to setting up a general practitioner with a special interest (GPwSI) service (2003), much of which is equally relevant to AHP PwSIs.

www.natpact.nhs.uk/special_interests

Any service redesign must be clear on its objectives, which should express patient need in terms of service outcomes. For example, patients with musculoskeletal conditions may be facing excessive waits for a first consultant appointment. An AHP P-led triage service might be an appropriate way to overcome this bottleneck in the system.

However, redesigning a service does not have to be prompted by a specific problem, as practitioners with special interests can make a positive contribution to many key service objectives, such as:

• improving patient access
• reducing waiting times
• increasing capacity in primary and secondary care
• improving the patient pathway
• making a more effective use of human and physical resources
Developing an AHPwSI service will require a suitable working group of local managers and practitioners including a GP and a consultant if possible. This group should determine whether or not the service is a local priority and agree the objectives of the service based on identified needs and resources.

The decision making process should be transparent to satisfy corporate and clinical governance and involve a wide range of stakeholders including practice and trust colleagues, referring GPs, supporting consultants and the public who will use the service.

Process mapping is an excellent way to engage different staff and stakeholders. Consider the pathway through care of a specific patient group, identifying all the staff who play a part in their care. This can highlight areas for improving the patient pathway, through the more effective use of staff skills, and can make a persuasive case for change.

Patients should be involved in each step of the design process:

- gather the opinions of those most likely to use the service through the patient forum or similar group,

- design the service and the AHP role around the patient’s needs, and the patient care pathway: focus on the points which make a difference to people’s experiences, and identify factors which might improve these points,

- assess patient satisfaction with the service as part of the evaluation process.

When designing the service, consider the following issues:

Clinical pathways

- Identify the care groups which will use the service, and the range of treatments or services they will require. How can these be most effectively provided (a single practitioner with appropriate support, a multi-professional team?)

- Identify the factors which will govern the route taken by a patient through the service. How do they access the service? What protocols govern their triage or referral, and their care management?

- Use data on existing services, good practice from redesigned services, and the knowledge of secondary care clinicians, to estimate the likely demand for the service and determine the implications for capacity. What is the
likely case mix of referrals? Which practices will refer to the service? How long will an appointment last? How many weekly sessions will be needed?

• Map out the working relationships between AH PwSIs and multi-professional team members, the acute sector, GPs and other practitioners referring to the service, plus social services and other relevant agencies. What links should be maintained between secondary care clinicians and the AH PwSI? Ensure that the AH PwSI has access to acute sector support, both in terms of clinical opinions and tests and resources only available in hospital. Where expertise is not available, the AH PwSIs will need to seek input from appropriate and recognised expertise from other parts of the country, and the professional bodies may be helpful.

• Agree reporting and accountability arrangements for practitioners working across organisational boundaries.

**Resources and administration**

• Identify an appropriate location for the AH PwSI service, which is convenient for patients and makes effective use of resources. Possibilities include:
  - A GP surgery
  - A health centre
  - A community hospital
  - A community-based location – in people’s homes, care homes etc.
  - A one-stop centre, a Treatment centre or a walk-in centre
  - An NHS Trust

• Ensure that costs of rent, or on-costs for funding clinics are agreed with the appropriate premises.

• Identify capital costs for any alterations or improvements which will need to be made to the premises. Similarly, what are the costs of equipment and supplies? Special attention will need to be paid to the costs of prescribing.

• Agree the arrangements for organising referrals and booking appointments, and managing follow-ups, and any subsequent programme of care. Ensure that the AH PwSI service has the necessary administrative and technological support.
Commissioning the service

- Design job descriptions and person specifications which clearly set out what the AHPwSI will do, what skills and knowledge they should possess, and their responsibilities. Agree the accountability and management arrangements. The clinical governance arrangements will follow those normally used for the employer organisations.

- The evidence of the AHPwSI’s competence to provide the service should be assessed against agreed local criteria. Obtain clinical and educational guidance on appropriate competencies, drawing on the expertise of the working group, secondary care clinicians and professional bodies.

  - Examples of competency guidelines for GPwSIs which might provide useful models, are available on-line at www.doh.gov.uk/pricare/gp-specialinterests

  - The NatPaCT PwSI website provides useful sample documents to help with this process, including sample contracts and a generic business case. From autumn 2003, an online database of PwSI services will provide key contacts willing to share their good practice. www.natpact.nhs.uk/special_interests

- Before appointing a AHPwSI, or commissioning an AHPwSI service, the employer organisation - a PCT, an Acute Trust, a mental health trust, or social services - should obtain evidence that the practitioner has the required competencies. A balanced assessment of the AHP’s professional competence should consider both formal qualifications and experience. Arrangements for this process of accreditation will be determined locally, but it is recommended that the external assessor is a recognised expert in their field.

- Agenda for Change should provide a useful means to decide on the appropriate level of salary for the post. Further details on Agenda for Change and draft evaluation tools can be found at www.doh.gov.uk/agendaforchange/

- An AH PwSI might be employed by a PCT, or an Acute Trust, but commissioning the service should be a partnership between primary and secondary care. Ensure that the commissioning process takes into account all relevant HR procedures and standing financial instructions. The practitioner should not be disadvantaged by working in a new way.

- The competencies for the service, the administrative arrangements, and referral protocols, should inform local guidelines on the use of the service, which can be distributed to all referring GPs, acute trusts, and other related organisations and practitioners. These guidelines can also be used in publicising the service to local people.
Education, training and support

• Formal clinical supervision should be provided, with regular appraisal or performance review. It is recommended that an AHPwSI has regular contact time with an acute specialist, either as part of their work in the multiprofessional team, or in dedicated sessions. Regular discussions would provide the opportunity for the AHPwSI to discuss problematic cases, clinical issues, and working arrangements.

• The AHPwSI would be expected to maintain their competencies as part of their continuing professional development and education.

• Additional training programmes can be identified drawing on the advice of professional bodies, Workforce Development Confederations, and teaching PCTs. However, useful experience and skills can be acquired through attendance at local outpatient clinics, and the support of a clinical mentor – this may be a specialist from secondary care.

• The CPD and support requirements, including funding, should be negotiated and agreed locally.

• It is recommended that the AHPwSI attends audit meetings and monitors service delivery, to evaluate:
  - case mix and referral patterns
  - clinical outcomes and quality of care
  - access times
  - patient satisfaction
  - critical incidents and significant events
Examples of AHPs with Special Interests

Community Orthoptic/Optometric Service, Birmingham Children’s Hospital NHS Trust

Outcome

Children referred from school vision screening are seen almost entirely in a local clinic/health centre as opposed to the acute service for vision checks by the Orthoptist and glasses tests by an Optometrist and are seen until the age of 7-8 years.

By seeing the children in a community setting, waiting times in the acute sector are reduced and children are seen nearer to home which reduces travelling time for busy parents and could reduce the amount of time children are absent from school.

How the need was identified

Following the departure of the Associate Specialist in Ophthalmology, a long term solution needed to be found for the provision of a service where no other Associate Specialists were available and a working party was established to look at the issue. The working party included a Locality Manager, a Consultant Ophthalmologist, the Head Orthoptist, a Hospital Optometrist and a representative from the Ophthalmic Services at the FHSA.

How the service was developed

Suitable Optometrists and Orthoptists were identified to work sessions at various health centres and see children referred from vision screening to test them for glasses under cyclopegia (eye drops) and receive payment from the FHSA.

There are strict guidelines and protocols for which children can be seen in the community clinics and which would need referral to an Ophthalmologist.

The FHSA already funded eye tests for children under 16 years through the General Ophthalmic Services (GOS) and payment is made directly to the Optometrist on a per patient seen basis.
Physio Direct – Hinchinbrooke Healthcare NHS Trust

Outcomes

Patients requiring physiotherapy simply telephone the department to receive advice over the telephone and, if necessary, an appointment, without the need for referral by a GP, thus improving access and reducing waiting. If secondary care is required, again waiting is reduced since the Consultant Physiotherapist or Extended Scope Practitioners can refer directly on rather than send the patient back to their GP first. The results are:

- High patient, GP and physiotherapy satisfaction with the service.
- Communication between patients, physiotherapists and GPs has improved.
- Reduced waiting times for treatment and time saved for patients, requiring advice only, who do not need to travel.
- Early access to physiotherapy means improved clinical outcomes.
- Possible reduction in the referral rate to Orthopaedic Consultants – specifically noted by GPs.
- Reduced lengths of appointments to a few minutes with GPs for musculo-skeletal conditions as the patient is simply given the contact number to ring.
- The DNA rate in physiotherapy has reduced from 15% to less than 1%.
- Improved career progression for physiotherapists who are now using their skills maximally.
- 70% of callers are managed with assessment advice only.
How the need was identified

Physiotherapists noted that patients were referred to physiotherapy later than necessary by their GPs and that access to their service was being limited.

How the service was developed

All the key players in primary care, the service, pharmacy and IT were involved at looking at the patient pathway and ensuring that the patient could access physiotherapy when they wanted to. Support was gained from the PEC and £15,000 made available for a pilot scheme. This funded an additional senior physiotherapist for 6 months. Following the pilot, a business case was drawn up to role the service out across the PCT.

The service has necessitated additional training for staff, new IT equipment and some building redesign.

Contact:
Jill Gamlin
Consultant Physiotherapist
01480 416091

ENT Voice Service, Speech and Language Therapist (SLT) Extended Role, York Hospital NHS Trust

Outcome

• A dedicated service for ENT patients with voice disorders
• SLT-led clinic assessment of new voice patients and SLT-led follow-up clinics.
• Improved multi-disciplinary working, including ENT/SLT competency framework and mentor scheme.
• Reduction of waiting times from a maximum of 16 weeks to 3 weeks and SLT waiting times from maximum of 6 months to 1 month.
• Reduction of follow-up appointments by 65%
• Similar clinics in the planning stage across England.
How the need was identified

The majority of patients attending a voice clinic are diagnosed with muscle tension dysphonia, and in most cases treatment for this condition is provided by the SLT. Allowing the SLT to assess a voice patient at the initial consultation enables him/her to collect the information necessary to plan appropriate therapy.

How the service was developed

A pilot project was started as part of Action On ENT and a number of Modernisation Agency tools and techniques were used to process map the patient's journey and to understand the demand and capacity issues. Patients were involved in areas of the work.

A competency framework was developed to ensure appropriate skills and occupational standards were used for the clinic, which were then appraised by SLT/ENT experts. The Developing a Curriculum (DACUM) model of competency-based assessment was used in order to assess the performance of the extended role practitioner.

ENT/SLT teams interested in developing new ways of working have formed a peer group which has been supported by Action On ENT.

A national conference organised in collaboration with the Royal College of Speech and Language Therapists, British Association of Otalaryngologists, British Voice association and Action on ENT is planned for 2004.

The pilot project was funded by the Action On ENT Modernisation Agency but is now permanently funded by the Trust.

Contact:
Emma Walker
ENT Speech and Language Therapist
Department of Otolaryngology/Head and Neck Surgery
Wigginton Road
York
YO31 8HE
01904 726208
Diagnostic radiography service, South Devon Health Care NHS Trust

Outcomes

- Waiting lists for barium enemas have decreased from 20 weeks to about 8 weeks.
- Waiting lists for other radiologist specific screening studies have fallen as time has been released for other examinations.
- Morning lists can be filled with specific studies such as paediatric examinations or orthopaedic/pain clinics.

How the need was identified

Historically there were two morning lists performed by Radiologists, comprising a variety of examinations, mostly barium studies (upper and lower GI), but also paediatric examinations and other tests requiring real time imaging. The new role of radiographers performing barium enemas was developed to offer a more timely service to patients, and to maintain lists previously lost to leave, and sickness.

How the service was developed

A total of four Radiographers underwent specific training in Leeds doing their practical work under supervision in the local hospital. After qualification this enabled them to independently perform barium enemas and to discuss their results with the Consultant Radiologist. (They are paid at senior 1 level for their sessions.) The initial training in barium enemas was funded by the department. This enabled the department to book lists consistently and the radiographers covered each other for leave and sickness resulting in no cancelled patients. Radiologists were then free to perform other screening examinations including paediatrics benefiting another group of patients.

This role is being extended further. Two of these radiographers are studying for a PgC in GI reporting, which will allow them to report on barium enema examinations. The PGC in GI reporting was funded by the Workforce Development Confederation, the Cancer Collaborative and the department. This is part of a growing trend whereby appropriately trained radiographers will contribute to the reporting workload releasing radiologist time for more complex examinations and interventional work.
Knee/Hip replacement service, Mid Devon PCT

Outcomes (of pilot project)

- All patients seen by practice physiotherapist before referral to secondary care.
- 21% of patients managed in primary care who would previously have been referred directly to secondary care.
- 91% of all patients seen by the physiotherapist felt the service had been useful.
- Conversion rate to surgery increased from 44% to 73%.
- Closer collaboration between GPs, practice-based physiotherapists and secondary care.
- Decreased impact of joint disease on the patient’s life.

How the need was identified

An audit of the patient’s journey showed that only 11% of patients referred to orthopaedics from primary care with degenerative hip disease had seen a physiotherapist prior to referral. The conversion rate to the surgical waiting list was low at 44%. Of those not listed for surgery, 38% were followed up in secondary care and 62% were referred back to their GP.

How the service was developed

After the success of the pilot project, Mid Devon GPs were encouraged to refer all patients being considered for potential hip and knee replacement initially to their practice physiotherapist. The New Zealand Priority Scoring Scale was used as a baseline measure, assessment, lifestyle and exercise advice was given. If referral was indicated, the NZ score was included with the referral letter. This process has been taken up by 2 neighbouring PCTs.
Contact:
Sue Bond
Mid Devon PCT
Newcourt House
Old Rydon Land
Exeter
EX2 7JU
sue.bond\@middevon-pct.nhs.uk

Parkinson's Disease clinic, Barnet PCT

Outcomes

• Improved patient and carer satisfaction with the service.
• Consultant time freed up for more complex cases.
• Early access to clinical specialists in primary care for assessment and treatment.
• Improved access to a specialist multi-disciplinary team (doctor, nurse, pharmacist, physiotherapist, occupational therapist, speech and language therapist and dietitian).

How the need was identified

It was noticed by the day hospital nursing staff that there was an increase in GP referrals for treatment and review of local patients with Parkinson's Disease due to a limited access to secondary and tertiary care.

How the service was developed

The multi-disciplinary team was identified from existing clinicians with specialist knowledge and interest. Protocols have been developed to include criteria for referral, treatment protocols and note-keeping and a series of training sessions were organised to enhance the skills of staff.

The service has been cost-neutral and has enabled greater liaison with the Parkinson's Disease Society, the Neurological Alliance and the Hospital for Neurological Diseases.

All evaluations of the service have been very positive.
Sonographers (Diagnostic Radiographers trained in ultrasound), Direct GP referral for PMB assessment, Addenbrooke’s NHS Trust

Outcome

- GP direct referral into radiology following agreed guidelines.

- Reduction of about 40% in gynaecology outpatient appointments for post menopausal bleed.

- Radiographers trained in ultrasound diagnosis and refer to the consultant gynaecology oncologist or back to the GP.

How the need was identified

Gynaecology and radiology audited the outcome of ultrasound results looking at the ratio of normal: abnormal diagnosis following ultrasound as the first diagnostic tool and then hysteroscopy to confirm abnormalities. Just over 40% were normal with the remainder needing some kind of intervention. It was therefore agreed that patients could be referred direct from the GP to radiology and only if the diagnosis was abnormal or equivocal would the patient need to attend the outpatient clinic.

How the service was developed

A meeting was held with all stakeholders, radiology, gynaecology and a GP representative. Following discussion of the audit results a proforma was drawn up for referral along with guidelines and letters for normal/abnormal outcome. The hysteroscopy waiting list was cleared and a system of referral set up. Women with Post menopausal bleeding are referred from the GP straight to the radiology department using the referral letter. After the ultrasound which is done within 2 weeks the patient is either discharged back to the GP or referred to the clinic, usually on the same day. GPs are still able to refer the patient back to the specialist if they have any concerns but patients with an abnormal diagnosis are seen quickly and then treated as appropriate. Using the ultrasonographers has enabled this to happen. This has saved about 40% of outpatient appointments.
Diagnostic radiography, Addenbrooke’s NHS Trust

Outcome

Two radiographers are performing barium enemas independently alongside the Radiology Consultants and Specialist Registrars. The barium enema waiting time has decreased from 3 months to less than 2 weeks enabling not only the 2 week wait for cancer diagnosis to be delivered but delivering an efficient service for all patients requiring this investigation.

How the need was identified

The routine waiting time for barium enemas was 3 months. The cancer targets included a 2 week wait and we did not want to increase the wait for all other patients, who also could have cancer, by delivering differential waiting times.

How the service was developed

A senior radiographer with an interest in GI work wanted to gain the skills to perform barium enemas independently. We took the idea to our Radiology board where we had to convince the Radiology consultants that this would deliver an improvement in patient care, a reduction in waiting lists and have no detrimental effect on the SpR’s in training. This took about 6 months. The GI specialist radiologist agreed to mentor the Radiographer.

The radiographer attended the barium enema course at St James Hospital, Leeds spending an initial 2 days attending the academic part of the course. He then returned to Addenbrooke’s and undertook 100 barium enemas under supervision. He then returned to Leeds to do further study and after examination and assessment was deemed qualified to perform barium enemas independently. We have trained a second radiographer to undertake this role.

Joint reporting takes place with the Radiographer and the Consultant in line with RCO R guidelines that 2 people should report on these examinations. The radiographers have 2 lists of their own and get paid as an advanced practitioner whilst undertaking this role. Continuity of this person in the role has improved.
training in the area and delivers a very effective specialist service to the patient. Both radiographers undertake yearly audits of their detection rates, which are comparable with those of the Consultant staff. The Trust indemnified the Radiographers doing this work.

Contact:
Liz Hunt
Radiology Department
Addenbrooke’s NHS Trust
Hills Road, Cambridge
CB2 2QO
01223 216271
elizabeth.hunt@addenbrookes.nhs.uk

Podiatry/Orthopaedic Foot and Ankle triage, Torbay PCT

Outcomes

• Reduction in orthopaedic waiting list – patients are seen earlier than if they had been booked to see the orthopaedic surgeon.

• Working as a team has resulted in efficient liaison between team members, thus reducing any delays in seeking second opinions and advice.

• Only 8% of patients referred to the podiatrist needed referring back to the orthopaedic surgeon for surgical intervention. The remainder of the patients were either:
  - Treated and discharged by the podiatrist.
  - Referred to the orthotist for footwear.
  - Referred to the physiotherapy department for exercises and/or treatment.

• Situating the podiatrist at acute Hospital provided rapid access X-rays and thus reducing delays for patients and aiding diagnosis.

• Patient being treated by a podiatrist instead of an orthopaedic surgeon is cost effective.

• Easier cross referral, quick and effective communications.

• Greater understanding of the skills of other professions.

• About 90% of patients were open-minded to footwear advice and conservative treatment and were satisfied seeing a podiatrist rather than the orthopaedic surgeon.
How the need was identified

Around England podiatry clinics are developing this type of service with orthopaedics. Following a presentation by another podiatry manager, the podiatrists approached the orthopaedic business manager and surgeon to see whether this idea could be progressed locally.

How the service was developed

The service was piloted for six months and funded by the orthopaedic department. At the same time, an audit identified the benefits of providing such a service. The team used the results to provide evidence to the PCT commissioners to secure funding from the Local Delivery Plan. Funding was provided and this service is fully established with a further audit in progress.

Contact:
David Harborne
Webster Home
Newton Abbot Hospital
East Street, Newton Abbot,
Devon, TQ12 4PT
01626 357323
david.harborne@nhs.net

Community Paramedic, East Anglian Ambulance NHS Trust

Outcome

- 77% of patients who were previously attending A&E are now receiving more appropriate and timely care in their homes, at the GP surgery or attending hospital through a more appropriate admission pathway.

- The percentage of category A calls responded to within the target time has increased from 55% to 85%.

- 49% of patients now remain within the community rather than go into hospital inappropriately.

- In the practice concerned with a list of 10,500, a projected cost saving of £28,729 per annum on A&E services has been calculated. If rolled out across Norfolk, the predicted savings could be as much as £2.2 million per annum.

- 56% of ambulances were stood down from proceedings on blue lights, 31% were completely stood down and a further 25% went onto proceed under normal road conditions. This reduces the risk to crews and other road users, thus placing crews under less stress.
How the need was identified

The model was introduced originally to reduce the unintentional barriers that can restrict access to care for patients within a resource-limited environment. It was felt that it was the most seriously ill or the most socially disadvantaged patient that is least able to negotiate these barriers.

Receptionists have traditionally had the unenviable task of managing medical help seeking usually through their control over appointments. Meanwhile doctors multi-task trying to keep up with demand by booking full surgeries whilst being on call for emergencies.

Obviously something has to give and it is usually immediate need, which is then transferred onto the emergency services. Once transferred the patient will often travel down an inappropriate care pathway resulting in placing ever more strain on the A&E ambulance service and A&E departments. This was frustrating for all concerned, not least the patient. The aim was to provide a service specifically designed for immediate need and to remove the barriers to entry.

How the service was developed

The scheme originally started as a need to meet 75% of category A calls within 8 minutes within rural areas by basing paramedics within GPs surgeries. However, the team felt that there had to be a better way of dealing with much of the workload rather than chasing after response time targets. Rather than “firefighting” it was decided to embark upon “fire prevention”. In other words rather waiting for calls to end up within the 999 system why not give patients a viable alternative for the cases that do not need a 999 call with safeguards built in. It has proved that if patients, and doctors, are given an alternative to using the A&E service (provided that there are safeguards) they are willing to use it. This is especially so in an area that is 20 miles away (or more) from the nearest A&E department. The ACAPON scheme was developed in response. The added advantage is when there is a patient that needs emergency medical treatment and uses the 999 system to access it there is a paramedic who is local and able to respond.

Each day a doctor, nurse and paramedic assisted by a health care assistant make up the duty team. The duty doctor and nurse have only a few booked routine patients each day mainly concentrating on the ACAPON patients. A patient who feels they need to be seen on the same day contact surgery reception. The receptionist takes the patients details and places it on the surgery’s intranet system called ENCOMPASS. The doctor will then work through the list, and then phone the patients back in order to interrogate the patient over the telephone. At this point the doctor will decide on the urgency of the patients condition. If the patient is considered to very unwell the paramedic will be dispatched to see the patient in the community, calling for ambulance back up if necessary. On arrival the paramedic will carry out an assessment and either make the decision to admit the patient as an emergency either through A&E (mostly for traumatic injuries),
CCU or Medical Admissions Unit in the case of an acutely unwell medical patient. If the patient does not need this degree of urgency the paramedic will contact the duty ACAPON doctor and relay information found during the assessment. A decision will then be made on the most appropriate course of action.

If the patient does not require an urgent home visit they will be invited to attend the surgery and the doctor will allocate the patient to the most appropriate individual to assess their needs. A full work up and history will be taken and the duty doctor, being in possession of this information, can then decide on the most appropriate course of action, and further investigations/ treatments can then be carried out or arranged if need be.

A patient presenting as a walk in case will be placed on the intranet system in the same way, and will be seen by a member of the team allocated by the doctor, or a member of the team if they are not too busy will pick up the message and see the patient and tell the doctor that they have done this.

All members of the team monitor the intranet system as any patient who contacts the surgery with “red flag” symptoms will be highlighted in red. The team would then take appropriate action if the doctor is busy and unable to deal with the message.

The system is absolutely dependent on teamwork, no one works in isolation. It has required a considerable degree of cross over training between specialities and the breaking down of traditional barriers. The paramedic does have admitting rights to the local hospital.

Contact:
Mark Eardley
Community Paramedic
Mark.Eardley3@btopenworld.com

Dietitian-led Coeliac Clinic - Royal Bournemouth and Christchurch Hospitals NHS Trust

Outcome

Care of coeliac patients now in line with British Society of Gastroenterology recommendations. Patients are seen promptly by a dietician once diagnosis has been confirmed, and three months after first appointment, then at six months, then yearly thereafter. Compliance to diet is checked using patient questioning and detailed diet history assessment. This has resulted in improved patient and consultant satisfaction, an audited improvement in compliance to diet, and a reduction in referrals to the consultant.
How the need was identified

Need was identified due to lack of support for this patient group. The BSG guidelines and evidence indicated that regular follow-ups lead to better compliance, which in turn leads to decreased complication rates.

How the service was developed

The service developed through discussion with one particular Gastroenterologist who was keen to see dietitians extend their role.

Protocols were developed for looking at blood and D exa scan results and were approved by the Gastroenterologist.

Given the results of this development, funding is being sought.

Contact:
Susan Geldart
Nutrition and Dietetic Services Manager
Royal Bournemouth and Christchurch Hospitals NHS Trust
Castle Lane East
Bournemouth
Dorset
United Kingdom
BH7 7DW

Community occupational therapist, Cambridge City Primary Care Trust

Outcome

• improved patient care and positive health outcomes for the patients.
• early intervention.
• improved multidisciplinary team working, where professionals are working alongside general practitioners, practice nurses, district nurses, community physiotherapist and others.
• improved management of patients with complex needs.
• improved understanding of the occupational therapy process and the role.
• prevention of admission to hospital and facilitating early discharge.
• support life choices for patients with terminal conditions to remain at home or live at home longer.

• early referral from paramedics avoiding admission to hospital via Accident and Emergency Departments.

How the need was identified

The need for the review of the community occupational therapy service was identified following a year-long review of occupational therapy services within the area and was part of the social services' Best Value Review. There was a year spent mapping the services from both health and social services by an independent consultant. Time was spent mapping the needs, carrying out literature searches, focus groups, reviewing patient pathways, listening to the patients' stories and journeys and reviewing stakeholders' needs as well as looking at the occupational therapy process.

As a result of this review five options were presented and it was agreed that an integrated occupational therapy service would be the best option for improved patient services. The changes to services would be cost neutral and pooled resources and budgets would be developed. Protocols have been developed to include criteria for referral and eligibility.

The service identified training needs and core skills for occupational therapists and a self-assessment tool was used. This enabled services to identify training, skills and experience and needs were recognised and learning opportunities developed. Sharing of expert skills and experience was also important to developing the service.

How was the service developed

The Community Occupational Therapist has developed the role into five key areas of intervention following assessment and identification of need.

1. Health promotion, e.g. programmes that encourage active healthy living, ‘Walk Tall, Don't Fall Campaign’.

2. Secondary prevention, e.g. including lifestyle modification by introducing physical activity self help education programmes.

3. Community rehabilitation, e.g. Balance and Safety Group that focuses on patients who have fallen, or are afraid to leave their home or need more confidence to be mobile and live independently.

4. Equipment provision, e.g. accessing and providing the appropriate equipment to maintain and facilitate independent living at home.
5. Adaptations to home environment, e.g. provision of a shower level access or ground floor extension.

The Community Occupational Therapist requires a high level of practice experience, skill and expertise and a body of knowledge across a wide range of clinical conditions and a broad spectrum of interventions.

Contact:
Jane Crawford White
Team Leader
Cambridge City PCT
Heron Court
Ida Darwin Hospital
Cambridge Road,
Fulbourn
Cambridge
CB1 5EE
janecrawford-white@cambridgenc-pct.nhs.uk
Appendix A

Professional accountability and legal framework.

1. Professional standards.
All AHPs must be registered with the statutory regulatory body the Health Professions Council. The HPC has responsibility for protecting patients by maintaining a register of members of all health professions, setting standards of education and training, and proficiency, and investigating complaints.

The HPC standards of proficiency are available on-line at www.hpc-uk.org/publications/index.htm

2. Legal standards.
There are two legal standards applicable to the expansion of the role of an AHP. The constitutional standard (‘the rule of law’) requires an AHP to act within the law. The minimum quality standard (‘the rule of negligence’) requires an AHP who takes on a role or task previously performed by another health professional, to perform that role or task to the same standard as that health professional. It is essential that AHPs undertaking new roles are aware of the legal boundaries relating to their role, and that they have sufficient training and preparation to ensure that they can perform the role to the required standard.

3. Employers liability.
When an AHP is employed by an NHS organisation, that organisation has vicarious liability for the AHP’s actions. This is in addition to the AHP’s professional accountability to the HPC.
Appendix B

Further information

Practitioners with special interests. A Step-by-Step Guide to setting up a general practitioner with a special interest (GPwSI) service (NatPaCT, April 2003).
www.natpact.nhs.uk/special_interests

Implementing a Scheme for General Practitioners with Special Interests
(Department of Health/Royal College of General Practitioners, April 2002).
www.doh.gov.uk/pricare/gp-specialinterests/gpwsiframe.pdf

Implementing a scheme for Nurses with Special Interests in Primary Care
(Department of Health, April 2003).
www.doh.gov.uk/pricare/gp-specialinterests/nurseysi.pdf

Department of Health Practitioners with Special Interests pages.
www.doh.gov.uk/pricare/gp-specialinterests/index.htm

National Primary and Care Trust Development Programme Practitioners with Special Interests pages (includes sample contract, job descriptions, and other useful documents).
www.natpact.nhs.uk/special_interests

The Changing Workforce Programme has a toolkit to help PCTs and staff to develop new roles to address service problems.
www.modern.nhs.uk/cwp

Practitioners with Special Interests Team
National Primary and Care Trust Development Programme
2nd Floor, Blenheim House,
West One,
Duncombe Street
Leeds LS1 4PL

Tel: 0113 2543846
E-mail: vicky.ward@doh.gsi.gov.uk

Implementing a scheme for Allied Health Professionals with Special Interests