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AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí
MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

PROPOSALS
FOR
HEALTH & SOCIAL CARE
REFORM

Consultation Response Questionnaire

CONSULTATION RESPONSE QUESTIONNAIRE
You can respond to the consultation document by e-mail, letter or fax.

Before you submit your response, please read **Appendix 1**, at the end of this questionnaire, regarding the Freedom of Information Act 2000 and the confidentiality of responses to public consultation exercises.

Responses should be sent to:

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RESPONSES CANNOT BE CONSIDERED AFTER MONDAY 12 MAY 2008

We are responding: as an individual ☐ on behalf of 6 organisations ☑

(please tick a box)

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Job Titles: Policy Officers/ Professional Officers

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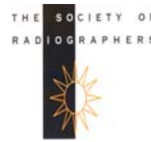

1. **Introduction**
   The College of Occupational Therapists (COT), the Royal College of Speech and Language Therapists (RCSLT), the Chartered Society of Physiotherapy (CSP), the Society & College of Radiographers (SCoR), the British Dietetic Association (BDA) and the Society of Chiropodists and Podiatrists (SCP) are pleased to provide a response to the Department of Health, Social Services and Public Safety's consultation, 'Proposals for Health and Social Care Reform' (18 February 2008).

2. COT, RCSLT, CSP, SCoR, BDA and SCP are professions within the family of the 'Allied Health Professions'. For the purpose of this response we refer to ourselves collectively as Allied Health Professionals (AHPs). We have provided more information on our individual professions at the end of this consultation response

3. AHPs work with children and adults of all ages who are ill, are asymptomatic, have disabilities or special needs. Their particular skills and expertise can often be the most significant factor in achieving an accurate diagnosis, treating patients with cancer, helping people to recover movement or mobility, overcome visual problems, improve nutritional status, develop communication abilities and restore confidence in everyday living skills.

4. AHPs must be registered with the Health Professions Council (HPC). The HPC is an independent, UK wide regulatory body responsible for protecting the public by setting and maintaining standards of professional training, performance and conduct of the healthcare professions it regulates.The HPC introduced 'protection of title' for Allied Health Professionals, which means that only a registered professional can use these titles.

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Q1. The Department is seeking your views on the functions, constitution and governance proposals for the new Regional Health and Social Care Board.

We support the proposals to establish a new Regional Health and Social Care Board (RHSCB) for health and social services in Northern Ireland to replace the four Health and Social Services Boards. There is considerable benefit in the establishment of a single regional strategic planning authority which will look at the delivery and performance of health and social care services. This move is consistent with the proposals contained in Best Practice Best Care, which seeks to ensure that the same standard and quality of healthcare provision is accessible to everyone in Northern Ireland no matter where they live. We support the constitution of the Board to reflect the cardinal principals of good governance, the focus being on the quality of care for patients and clients, accountability, transparency, efficiency and effectiveness. The proposal to have "a much more focused, streamlined organisation" to ensure value for money, avoid duplication and deliver appropriate services is also to be welcomed.

We agree with the core functions outlined for the Board of "performance management and improvement, commissioning and financial management". However in relation to performance management it is essential that local provision is assured and not adversely affected by targets set at a regional level. From a financial management perspective, local commissioners need to have the necessary financial control to be able to effect real change when designing services to meet the need of their local population.

We further support the intention in tandem with the creation of the RHSCB, to conduct a review at Departmental level which will examine the Department's structure, role, functions and staffing in order to drive forward the reform agenda. AHPs have consistently argued that how the new HPSS agencies are structured is critically important for the reform and modernisation of services. It fundamentally impacts on how services are delivered across boundaries and on how resources are directed toward front-line services. The management structures at Departmental, Regional Board, Trust and Commissioning level must reflect adequate representation for AHPs to ensure that healthcare professionals involved in the planning and delivery of services can play a part in developing effective, efficient, integrated, patient centered services.

The current lack of representation for AHPs at all levels has created a situation where the valuable views of those professionals are often overlooked in relation to the planning and commissioning of services. It is the view of the professions that the current inequitable representation of AHPs at all levels within the health service represents a serious challenge to the reform of services from a traditional, reactive, illness-treating model to one that is more proactive, preventative, and health-promoting. Better more equitable representation for AHPs would provide a significant opportunity to develop more innovative and creative ways to address long-established problems. It would facilitate better partnerships with professional colleagues in overcoming real and perceived boundaries between services and organisations, and it would help develop ways of working that will be of benefit to patients and the people who use services.

Q2. The Department is seeking your views on the functions, constitution and governance proposals for the Local Commissioning Groups, including membership.

AHPs recognise the importance of playing a full and active role in the commissioning process in order to optimise the contribution they can make to better, more cost-effective patient services. AHPs perform essential diagnostic and therapeutic roles within healthcare and across many other sectors - for example, in social care and education. Increasingly AHPs are working in both primary care and acute settings as part of multi-disciplinary teams. They are bringing their skills to an increasingly integrated response to patients needs, especially in the important areas of older people's care and wider preventative health. The commissioning process in Northern Ireland must therefore focus on improving access, enhancing quality and securing good value for money. If commissioning is to ensure an increasingly effective response to local needs it will depend on the effective engagement and insights of AHPs.

We strongly support the intention to **"have very strong links with local communities, with voluntary and community sector organisations and the engagement of communities in securing the health and well being of their people."** It is essential that the new structures ensure that the needs of our patients have appropriate forums for planning and commissioning. Previous structures failed to sufficiently engage the full range of professionals in the planning and commissioning of services to meet the needs of users requiring therapeutic interventions.

We support the establishment of five Local Commissioning Groups (LCG's) coterminous with the exiting five Health and Social Care Trusts. We believe that this will provide a more responsive local mechanism for commissioning our patients' services. The new arrangements should promote an inclusive approach to the development of regional objectives and the staff tasked with delivering frontline services should have real ownership in implementing those objectives. The new system and structures, above all else, must be accountable to the population they serve and have open, inclusive, consultative and transparent processes, which are readily accessible to public and staff alike. We very strongly support the intention to ensure the promotion of health and wellbeing as central to commissioning. It is essential that greater emphasis is placed on prevention and health improvements. This is an area where AHP's skills have been significantly under utilised in the past.

AHPs are committed to ensuring the integration of AHP skills into multi-professional teams designed around the needs of the patient. We support the inclusion of at least one dedicated Allied Health Professional representative on each of the management boards of the LCGs. The appointment of 5 AHP representatives as commissioners (one to each LCG) offers excellent opportunities for AHPs to be involved in or lead the process of redesign, and to assume appropriate roles along the redesigned care pathway. This will help ensure that there is real partnership in the commissioning process with access to a senior allied health professional who has a strategic overview of existing services and the needs of patients. This is vital to ensure that a comprehensive approach is

taken to the development and integration of services. Without this, workforce development plans and service delivery objectives, set by individual organisations will fail to deliver a co-ordinated and cost-efficient use of AHP services.

From a user perspective, the introduction of positive measures which encourage wider participation in deciding priorities and allocating funds for the delivery and design of health and social care are to be welcomed. Greater co-ordination and integration of public administration is vital to ensure a common ethos and approach to service provision across sectors. It is essential that LCGs develop effective mechanisms for engaging with local populations and the wider community to enable those groups to shape the design of improved patient pathways, and to introduce community-based services that are more convenient for patients. We firmly believe that local communities should be an integral part of the public administration system to ensure that decisions on services more fully reflect the needs of particular communities.

Regarding the commissioning process itself, further clarification detailing the mechanisms and extent of financial control to be devolved to Local Commissioning Groups is required. Further detail is required on the extent of LCG's delegated responsibility to commission services and the development of the proposed "Scheme of Delegation", specifying the roles and responsibilities of the commissioning groups. Clarification on these issues will be essential for effective governance arrangements for LCGs. It is our view that adequate resources and financial controls should be devolved to these groups to ensure that commissioning is effective. This will require a high level of professional support, including input from public health, social services, nursing, allied health professionals, planning, finance and information.

Q3. The Department is seeking your views on the process for obtaining local government representation on the Boards of the Local Commissioning Groups.

Regarding the composition of these groups the involvement of democratically elected local representatives is to be welcomed. We believe that this will help ensure that commissioning is subject to a much more democratic and accountable process. Local elected representatives should be integrally involved in deciding on the priorities for public services in Northern Ireland and in making appropriate decisions regarding the allocation of resources for those services. It is important to involve local political representatives in the commissioning arrangements. Councillors are the bedrock of local democracy and can act as champions for the commissioning groups. It will encourage political parties to work together to improve services for their constituents. Local government involvement will further allow service users to channel their concerns about the quality of health and social care services being provided.

Q4. The Department is seeking your views on the functions, staffing and governance proposals for DHSSPS.

We agree with the responsibilities for the Department currently outlined in the consultation paper and endorse the Department's intention to ensure that

"there is strong professional leadership for health and social care".
We believe that professional leadership is fundamental in:

1. the development of policy and professional standards
2. providing effective professional governance frameworks
3. providing support for the regulation of the professions
4. ensuring safe, effective, evidence based practice by applying their profession specific knowledge.
5. and in carrying out the Department's responsibilities as outlined in the consultation document (para 5.2)

We would stress that the Department needs to employ staff from all relevant professions to fulfill these functions and that there should be strong professional leadership in both the DHSSPS and the new RHSCB. AHPs must be actively involved in delivering on public health work, performance planning, workforce and the commissioning of education and training, the development of service frameworks, service agreements and strategic policy development including targets and health and well being outcomes.

The Department needs to ensure that it develops a strong partnership with professional bodies and has identified equitable structures for AHPs within the DHSSPS and RHSCB to ensure that clients' needs are appropriately identified and met.

The development of policy and professional standards
AHP leads would provide advice to the Minister and the Department to ensure that all health and social care professions can actively be involved in the formulation of policy to ensure that it is both evidence based and achievable by the RHSCB. AHPs must always be involved in the interpretation of national professional policies for their specialist areas. Professional leaders can assist the Department with guidance and knowledge on policy issues that non-AHPs are unlikely to be able to provide.

Providing effective professional governance frameworks.
AHP managers and leaders have detailed knowledge and experience of working in a multi disciplinary way that will be of real benefit to the delivery of integrated care pathways. AHP leaders have the knowledge, skills and experience to ensure that clinical practice is developed and delivered on the basis of evidence of efficacy. We believe that having AHPs in leadership roles provide assurance of risk management.

Providing support for the regulation of the professions
The Department will want to ensure that professional practice is safe and complies with Healthcare Commission standards. Ensuring safe, effective, evidence-based practice is essential when dealing with patients. Requirements for continued re registration for the Health Professions Council (HPC) depends on evidenced Continued Professional Development (CPD), therefore time and resources will need to be given alongside recognition of the wide range of learning opportunities that make up CPD.

Ensuring safe, effective, evidence based practice by applying their profession specific knowledge
We welcome the Department's focus upon setting standards of care and agree that the transfer of the Research and Development office would be a positive action in improving services and patient outcomes. We believe it is important that AHPs are involved in the design of care pathways and programmes for patients with therapeutic needs to ensure that evidence based practice is embedded within the pathways and programmes and everyday working practice.

AHPs must always be involved in the planning and delivery of training of others who are involved in the care of people who require their specialist skills.

We strongly believe that:

- The Department should maintain a strong professional leadership function to ensure that users needs can be planned, delivered and met according to agreed professional and service specific standards.
- The Department should be more explicit in its functions about how it will involve users at the policy development stage.

Q5. The Department is seeking your views on the additional functions, staffing and governance proposals for the common services organisation.

We support the creation of a Common Services Organisation. As to additional staffing and functions we would generally be supportive but would have concerns in relation to accountability and organisational structures. There needs to be more details and clarification of the relevant functions located within the CSO. Arrangements need to be put in place to ensure appropriate involvement of AHPs.

Q6. The Department is seeking your views on the proposal to create a Regional Public Health Agency and the functions it would undertake.

Bringing together the key stakeholders within the area of health promotion will avoid duplication of resources and initiatives, enable sharing of experience and enhance the roll out of effective programmes. This will need to be accompanied by the pooling of finances to enable the achievement of the ambitious targets set out in previous DHSSPS strategic documents e.g. Fit Futures and Investing for Health.

How does the Department foresee these arrangements working in practice in terms of balancing the benefits of co-ordination at a regional level whilst maintaining the 'local' element in terms of recognition of local issues, needs and support?

At present the Health Promotion Agency is a Special Agency of the DHSSPS reporting directly to the Department. The document does not comment on the reporting mechanism for the RPHA within the new Health and Social Care structures. The Health Promotion Agency must ensure that all health and social care professions including AHPs can actively be involved in the formulation of health promotion policy to ensure that it targets those aspects of self care which

have traditionally been provided by AHPs.

The HPA also has strong links with the Department of Education particularly around the issue of school meals provision -how will this relationship be maintained in the new structures?

The document does not comment on the roles and functions of other Government Agencies e.g. Food Standards Agency, Northern Ireland (FSANI) and Safefood, which also have a Health Promotion and Protection remit – how will these groups interact and collaborate with the RPHA?

Q7. The Department is seeking your views on the proposal to incorporate Health and Social Care Trust specialist health improvement functions into the Regional Public Health Agency.

Each of the HSC Trusts has a key responsibility to develop community initiatives to reduce inequalities and enhance the health of the local population. Many are already developing robust engagement strategies and have brought together the health promotion teams from the legacy Trusts. Having the support of RPHA will be crucial for the work of the HSC Trusts and will enable sharing of best practice across HPSS.

Q8. The Department is seeking your views on the proposal that, in the future, local government could be required, through legislation, to consult with the Regional Public Health Agency when developing its community plans.

Local government has a key role to play in the delivery of health messages to the public. It has local knowledge of the health and social issues facing its' constituents and should be more involved in delivering health care messages to its public. AHPs support the proposal that local government should consult more explicitly with the new RPHA to ensure that the wider public health agenda is communicated effectively at a local level. AHPs are already working with members of local government e.g. environmental health officers, sports development officers as well as Leisure Services, Housing and Education to promote key healthy lifestyle messages around activity and diet.

Q9. The Department is seeking your views on the proposal that the Regional Health & Social Care Board and its Local Commissioning Groups would be required, through legislation, to seek advice from the Regional Public Health Agency when developing their commissioning plans.

AHPs support the above proposal, as it will mean that commissioning will be targeted to reduce the health costs of the population in the long term whilst providing the necessary health interventions in the short term. RPHA can act as a conduit for best practice and signpost RHSCB and LCGs to other good practice examples. It will also be able to ensure that there is a regional collation of health promotion examples and this will benefit economies of scale.

Q10. The Department is seeking your views on the proposal to appoint the Chief Executive or a senior Executive of the Regional Public Health Agency as a non-Executive of the Board of the Regional Health and Social Care Board.

It will be important to have representation from RPHA on the RHSCB to ensure that the importance of Public Health is acknowledged and embedded.

Q11. The Department is seeking your views on the proposal of how to make the work of the Regional Public Health Agency fully multi-professional.

There has traditionally been a lack of recognition of the role of AHPs in Health Promotion. City University's Centre for AHP Research has been awarded a major grant by the The National Institute for Health Research Service Delivery and Organisation Programme (NIHR SDO), to examine the nature and extent of allied health professionals' involvement in health promotion across the UK. The aim of the research is to assist planners and providers in developing services, improving health and reducing health inequalities. This review will identify priorities for developing AHPs' role in health promotion. We believe that the RPHA must develop stronger multi professional representation in order to identify and meet the changing health needs of the population.

The RPHA will need to retain the multi-professional nature of HPA and IfH by bringing together the expertise of a range of disciplines. Programmes successfully designed and implemented by HPA and Investing for Health teams, many of which are multi-professional, need to be recognised and built upon.

The RPHA should have the resources to second or commission practitioners from relevant disciplines to work on specific projects at community level to ensure timely, effective and successful implementation. Much of the resourcing of community based projects has been on a short term basis or by external partners e.g. Big Lottery grants funding, thereby reducing the impact of intervention on long term health outcomes.

Q12. The Department is seeking your views on the proposals for the Agencies referred to in Section 8.

AHPs have a number of concerns regarding the ability of the current arrangements to deliver an effective service particularly in relation to clinical and social care governance. Clinical and social care governance provides an opportunity to create a single programme for quality improvement. We do not believe that the current arrangements in relation to the operation of the Regulation and Quality Improvement Authority provides sufficient support in addressing issues around quality and effectiveness for services provided by Allied Health Professionals.

Clinical governance is a corporate responsibility of the DHSSPSNI. As such all professions, all grades and each individual working in health and social care have a personal responsibility for the delivery of good care. AHPs involvement in systems and structures to support clinical and social care governance is crucial. All AHPs should be aware of their clinical governance responsibilities and the

contribution they can make to quality improvement systems and plans.

AHPs are concerned that the current arrangements within the Regulation and Quality Improvement Authority do not allow for their full participation in relation to the monitoring and regulation of the quality of health and social care services in Northern Ireland. AHPs are central to the modernisation agenda and it is therefore essential that AHPs are involved in those relevant initiatives designed to produce faster, high quality services. In addition AHPs need support to develop their new roles and responsibilities within the context of new multi-professional and multi-agency structures. It is vital therefore that management systems and structures within the new structures support AHPs in making a full contribution to the service.

Q13. The Department is seeking your views on the proposals for the two options, set out in Section 9, to replace the HSS Councils.

We support option 2, 'five separately constituted independent local bodies each operating within the same geographical areas as in option 1 as we believe this option will ensure strong local influence and be better placed to promote and represent the public interest. Structures in the Trusts are very individual and we therefore take the view that it is more important in this instance there are strong local bodies to engage with service providers and articulate the public voice and carry out the functions of the new organisations listed in 9.3. It will be important to engage at a grassroots level, as we feel information will be more accurate and pertinent. However we also recognise the importance of the need for a regional focus when appropriate. These bodies in carrying out their roles at a local level will influence the development of the regional agenda.

We support the view that the five bodies should be required by statute to work together on a collaborative basis. There must be mechanisms in place to raise issues both locally and regionally.

14. The Department is seeking your views on the constitution of the new organisation(s) under each of the proposed options, set out in Section 9, to replace the HSS Councils.

In looking at the constitution of the new organisation(s), current requirements for HSS Councils are that at least that 4/10 members are appointed from nominations submitted by relevant District Councils. We also note it is proposed that LCGs have 4 elected local representatives from the District or Borough Councils and further proposed that locally- elected representatives be appointed to the Board of the RPHA.

While the involvement of locally elected representatives is welcome there are important issues around these proposals that need to be examined in terms of the constitution of the new organisation(s). What will the implications be in terms of representation on these bodies of locally elected representatives; for example could the same person sit on two groups? There may be potential for conflicts of interest so what checks and balances will be put in place?

We also support the view that voluntary and community organisations should have

strong representation on whatever new replacement organisation(s) there will be for the HSS Councils.

We support the view that the merit principle will underpin the selection process of Board members.

Section 10 Reducing Costs and Bureaucracy

We are concerned that the policy for rationalizing existing management structures is having a detrimental effect on patient care. AHP professional managers no longer have responsibility for signing off requisitions for equipment. This has resulted in increased bureaucracy and not less. Requisitions now have to pass from therapist to professional head of service to AHP manager before the requisition is signed. This has resulted in increased waits for equipment. Recruitment has also been severely impacted by the new structures and staff teams are becoming frustrated at the slow process of recruiting to vacant posts.

10.4 Appropriate skill mix is required from both administrative and clerical colleagues to ensure the full and integrated delivery of AHP services at both a local and trust level. Time and time again, when new AHP posts are put in situ the additional funding required to fully support AHPs in their work has either been lacking or grossly under-estimated. Consequently over a long period there has been a demonstrable misuse of professional AHP time, which is then, deflected from providing patient care and treatment.

Whilst the Strategic Business case of 2006 may well have the aim to reduce and make more cost efficient the use of administrative and clerical colleagues, careful scrutiny must take place of the impact these changes may make on the working lives of AHPs and their ability to deliver high quality, responsive care to their respective patient groups. AHPs need to be closely involved in workforce planning to ensure the correct skill mix within local workforce.

10.5/6 AHPs are indeed supportive of this aspiration. However, we are concerned that the existing limited senior positions for AHPs in Trusts are being further impacted by RPA. The roles and career prospects of a high number of very experienced and valuable AHP colleagues are being cut in order to make further savings. Senior posts with both clinical and management responsibilities have now been identified as RPA impacted.

This contradicts the commitment given at the start of the RPA process, that frontline staff would not be affected by RPA. To date, there has been very little evidence of the AHP group benefiting from RPA nor indeed any proposals in the near future to plan for the enhancement of AHP services in response to PFA demands and the increasing demands from an aging and more chronically diseased population.

Section 11 Human Resources

The HPSS must ensure that any changes or proposed movement or losses of AHP staff, is fully rationalised and clearly understood, in both the delivery of care to patients and the impact these changes or losses will make to the medium and long

term prospects of care delivery and the AHP groups concerned. A very open and transparent partnership approach must be adopted to allow any of these changes to be consulted and negotiated on. Use of Public Service Commission Guiding Principles must be fully endorsed and the fulsome involvement and close working with AHP professional bodies and their unions and collectively by the agreed mechanisms, such as the Joint Negotiating Forum and Partnership Forum.

Whilst vacancy controls and the Employment, Redeployment, Voluntary Redundancy and Early Retirement Scheme (EVRER) have been used to achieve these aims, to date under RPA, there has been a concern recently that these are now being extended to envelop senior grades of AHPs. Secondly, the AHPs apparently affected have not been advised early enough in the process that they too would become a target of RPA and therefore have not been involved in both seminars to explain or outline how their posts will be affected. Subsequently there is a great deal of apprehension and uncertainty over their futures in the HPSS.

Those AHPs who have or may be displaced must be offered very similar work, not merely alternative work to ensure both the validity and aims of RPA and the correct implementation of agreed policies.

Human Rights

Q15. The Department is seeking your views on the human rights implications of the proposals for Health and Social Care reform and any issues you think relevant.

No comment

Equality

Q16. Can you identify any additional relevance evidence or information which the Department should have considered in assessing the equality impacts of these proposals?

Although these set of proposals are primarily aimed at the named organisations under 2.3, nevertheless a number of AHPs, either work for or indirectly work with groups of employees affected.

Due to the predominantly female make up of the AHP family of employees, it is essential that cognisance of the full Equality Impact Assessment (EQIA) is taken into consideration, at not only each and every step of this process, but also at each level and the potential impact in the medium and long term of these proposals on AHPs. This means a full and prolonged period of regular discussions and consultations with all affected or potentially affected AHPs.

Q17. Can you identify any other potential adverse impacts, with supporting evidence, which might occur as a result of these proposals being implemented?

Whilst the ethos of the reform agenda is to break down health inequalities and boundaries and provide a more efficient health and social care service for all users in Northern Ireland, many users of AHP services will be concerned at the lack of recognition of the distinct needs of children and people with a learning disability in this document.

There is a danger under the proposals that small complex populations, who may require specific interventions which may be long term, may be disadvantaged. These include groups like children with specific language impairment who do not fit a traditional programme of care descriptor and those requiring specialist funding for communication aids.

It is also disappointing that in this section questions on the impact upon staff come before the impact upon users.

Q18. Can you suggest any other mitigating measures to eliminate or minimise any potential adverse impact on the staff concerned?

No comment

Q19. Have the needs of the Section 75 categories of people been fully considered in this EQIA? If not, please provide details and supporting evidence.

No comment

Q20. Do the proposals afford an opportunity to promote equality of opportunity and/or good relations?

No comment

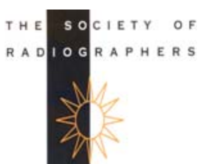
1. The College of Occupational Therapists (COT) represents over 28,000 occupational therapists, students and support workers across the United Kingdom, of which over 900 are either working or studying in Northern Ireland. Occupational therapists (OT's) work in the NHS, Local Authority Social Services and Housing Departments, schools, primary care settings, and a wide range of vocational and employment rehabilitation services.

   Occupational Therapists are regulated by the Health Professions Council, and work with individuals of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties. The philosophy of occupational therapy is founded on the concept of occupation as a crucial element of health and well-being. Practice is based on holistic, client centred care.

2. The Royal College of Speech and Language Therapists represents speech and language therapists and support workers, promotes excellence in practice and influences health, education and social care policies.

   There are around 10,000 practising Speech and Language Therapists (SLT) in the UK. Speech and language therapists work in a range of Primary, Secondary and Community Care environments. We also work in a variety of educational settings and have an in depth understanding of the challenges facing Health and Education in the coordination of services to children and young people. Speech and Language Therapists also work in courtrooms, prisons and young offenders' institutions and are often the key professionals involved in the support of offenders with Communication Impairment.

3. The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 45,000 qualified physiotherapists, physiotherapy assistants and students. Around 98% of qualified practising physiotherapists are CSP members. Physiotherapy is the third largest health care profession after medicine and nursing. Physiotherapists assess, treat and rehabilitate 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.



4. The Society & College of Radiographers (SCoR) is the professional, educational and trade union body for its members in the UK. SCoR represents 22,671 radiographers, assistants, support workers and student radiographers in the UK. SCoR members work primarily in the NHS but also in the independent sector and education and research.

   Diagnostic Radiographers and their support workforce have a key role to play in the imaging and diagnosis of disease and injury and are responsible for the examination of patients and clients using radiation, ultrasound and magnetic fields in a variety of clinical environments. In addition Diagnostic Radiographers are involved in interventional procedures.

Therapeutic Radiographers treat patients, mostly those with cancer, using ionising radiation. They are responsible for the accurate planning and delivery of a prescribed dose of radiation to specific areas of the body and deal with the wider aspects of oncology. Additionally, they play an important part in helping patients and their carers cope with the physical and psychological problems associated with treatment.

5. The British Dietetic Association (BDA), founded in 1936, is the professional association for registered dietitians in Great Britain and Northern Ireland. It is the nation's largest organization of food and nutrition professionals with over 5,000 members. About two-thirds of members are employed in the National Health Service. The remaining members work in education, industry, research, sport settings or freelance.

   Registered dietitians are the only qualified health professionals that assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Uniquely, dietitians 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.

   Dietitians are the only nutrition professionals to be statutorily regulated, and governed by an ethical code, to ensure that they always work to the highest standard. Dietitians work in the NHS, private practice, industry, education, research, sport, media, public relations, publishing, NGOs and government.. Their advice influences food and health policy across the spectrum from government, local communities and individuals.
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6. The Society of Chiropodists and Podiatrists (SCP), founded in 1945, represents over 8,000 Podiatrists in the UK. The majority practise in the National Health Service and in private health care in clinical, educational and/or managerial capacities throughout the UK

   Registered Podiatrists specialise in the assessment, diagnosis and treatment of diseases and conditions affecting the feet and lower limbs. Podiatrists provide a service to people from all age groups within all programmes of care across acute, primary and secondary health and social care settings. Following assessment, treatment is focused on restoring and maintaining functional independence enabling people to maintain their health and social wellbeing and live independently within their own community.