Learning from an allied health perspective on quality and safety

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Received 2 January 2025
Accepted 6 March 2025
Published Online First 18 March 2025

Linked

► https://doi.org/10.1136/bmjqs-2024-017746

To cite: Müller N, El Refaie A, McGrath M, *et al*. *BMJ Qual Saf* 2025;**34**:361–363.

In this issue of the journal, the article 'Developing the Allied Health Professionals workforce within mental health, learning disability, and autism inpatient services: Rapid review of learning from quality and safety incidents' by Wilson and colleagues[1] reviews materials on safety incidents in England published between 2014 and 2024, with a focus on the contribution of allied health professionals. In the context of this study, NHS England's definition of 'allied health professionals' (AHPs) was used, namely the 14 registerable professions of art therapists (art/music/drama), chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, paramedics, physiotherapists, prosthetists/orthotists, radiographers and speech and language therapists.[1] The review largely considers more extreme forms of harm, such as death (including homicide and suicide), abuse by staff and self-harm.

In this editorial, we take a reflective stance informed by critical discourse analysis. Critical discourse analysis concerns itself with the use of language and interactions in relation to power structures and differentials, how hierarchies are constructed, conformed to or resisted, within structures and institutions in society, including healthcare. A useful overview of the origins and fundamental tenets of critical discourse analysis can be found in Van Dijk's[2] chapter.

WHAT IS IN A NAME? IS THE STATUS OF ALLIED HEALTH PROFESSIONALS ENSHRINED IN A LABEL?

Wilson and colleagues provide an overview of the increasingly complex and varied roles of AHPs in the National Health Service (NHS) in England at all stages of healthcare encounters. Terminologies differ between health systems around the world, as does the number of professions included in the overall umbrella. For example, while AHPs in NHS England include the 14 professions listed above, the Health and Social Care Professions (HSCP) designation in Ireland covers 26 professions, including psychology, audiology, social work and others that are not in the NHS England definition but not including others such as art therapists and osteopaths.

A thorough discussion of the evolution of the term 'Allied Health Professional' would go beyond the scope of this editorial. However, the choice of the term AHP (evolved from 'Professions Allied to Medicine') does express a hierarchical relationship, in that it enshrines medicine as the anchor discipline in the therapeutic endeavour. It would be naive to assume that simply adopting a different label would automatically entail different (or absent) hierarchies. Hierarchies, or the acknowledgement of the prioritisation of different professional groups' contributions to good health outcomes and ultimately patient safety, are also entrenched in the (lack of) opportunity to advance within a clinical profession. In this context, it is relevant that health services and successive governments in the UK and Ireland have acknowledged the need to extend the scope of specialist practice for AHPs/HSCPs and to improve their access to clinical decision-making in order to improve patient outcomes. However, the development of advanced (clinical) practitioner frameworks underpinning systematic implementation is a relatively recent phenomenon.[3 4]

ORGANISATIONAL CULTURE AND DISCOURSES

In their findings and discussion, Wilson and colleagues make reference to the concept of organisational culture (defined as ways of thinking, feeling and behaving in an organisation).[5] The organisational culture

they portray on the basis of their review is one of deep inequalities in terms of how different parts of the workforce, and specifically AHPs, are recognised and enabled to contribute to patient care. Wilson and colleagues write of AHPs being 'quietened', 'disempowered' and 'excluded' from discussions and decision-making.[1] What is striking is that the central concern identified is one of discursive practices that prevent optimal collaboration between members of the multidisciplinary team (MDT). These discursive practices include a lack of both information giving and information seeking where needed, both in terms of face-to-face communication and of record keeping, and exclusionary practices (eg, lack of input on the part of AHPs and/or lack of participation in MDT meetings and lack of AHP involvement in patient care). Thus, what emerges is a picture of a rather dysfunctional communication culture. In this context, it is noteworthy that in the reports reviewed by Wilson and colleagues, the most frequently identified training needs relate to the care for autistic individuals, which entails significant learning for healthcare professionals about emotional and communication needs associated with autism, which in turn are the expertise of AHPs (eg, speech and language and occupational therapists). Staffing, both in terms of overall staffing profiles (mix of skills and expertise on the MDT) and staffing shortages (in some instances specifically in AHP roles), was also identified as a contributing factor in the materials reviewed. Wilson and colleagues also speak of this factor in terms of contributing to stress and low morale, which we can expect to also have a negative effect on open and supportive communication in the workplace. A negative discursive culture, in terms of how AHP staff felt acknowledged, valued, supported and understood in their roles and concerns, was also found to be perpetuated by senior staff and managers. A prevalence of low morale is likely to negatively impact patients' experience and safety. Conversely, it has been found that higher engagement and satisfaction among healthcare workers are linked to better patient outcomes, including reduced hospital-acquired complications and reduced cost.[6]

DO WE JUST NEED TO COMMUNICATE BETTER?

Our 'take' on the findings of Wilson and colleagues in the previous paragraphs is deliberately focused on discursive practices as a key factor in healthcare contexts that are manifestly problematic, since the basis of the review article is the documentation of very serious incidents. Of course, a conclusion along the lines that 'we all just need to communicate better' would woefully misrepresent the complexities involved in providing healthcare to very vulnerable individuals.

However, the findings of Wilson and colleagues indicate that counterproductive discursive practices, which prevent optimisation of what different members of an MDT can contribute, constitute not only one among many factors but are at the heart of several contributing factors across a corpus of documentation spanning 10 years. We find it important to note that Wilson and colleagues did not set out to unpack 'ways of thinking, feeling and behaving', that is, 'organisational culture',[5] but rather, problematic organisational culture became apparent as a prominent issue in the course of their analysis. This gives us pause for thought.

A large part of organisational culture is the discursive and communication practices that shape and perpetuate it. Some aspects of organisational culture are relatively flexible and open to change, such as the way interpersonal relationships develop and play out in a team and how momentary conflict may arise on an interpersonal level. Some roles in an organisation are expected to set the tone for team interactions (for instance, MDT leads, more experienced mentors for junior staff). Some ways of interacting, such as the conduct of regular team meetings, become habitual. This facilitates complex, multi-party interactions by making their structure predictable: everybody knows 'how this is supposed to go', even if there is no formal standard operating procedure. However, it can also become counterproductive if practices become habitual that privilege the participation of some groups over others (as found by Wilson and colleagues).

Organisational culture is also shaped by the professional scope, influence (eg, decision-making power) and identity of different professional groups, including AHPs. What one group is expected and allowed to do is defined in part by a pathway of qualification and professional experience; this accounts for professional scope. However, the understanding and identity of any one professional group is also negotiated within the wider context of the MDT, in as much as a mutual understanding of roles is a prerequisite for optimal contribution to joint goals. Additionally (and importantly), how different contributions are valued and prioritised is a matter of professional, social and policy discourses, which also intersect with constraints such as resource availability (and ultimately, the prioritisation of resources in terms of, for example, staffing levels across professional groups, or development within professions, is also a matter of complex negotiations, given that policy decisions and their implementation do not happen in a vacuum).

Wilson and colleagues conclude that there is a need for a 'cultural shift' in how AHPs are 'viewed, understood and included' in services. There is increasing evidence that in many contexts, foregrounding the role and contributions of AHPs/HSCPs can significantly benefit patients in terms of, for instance, access to services and therefore avoidance of potential complications as well as improved quality of life. For example, the evaluation by Ó Mír and colleagues[7] of an extended scope paediatric orthopaedic physiotherapy clinic found a reduction of wait times from 101.9 weeks to 15.4 weeks, with 77% of clients managed without medical consultant intervention. As a further illustration, the introduction of a speech and language therapy (SLT)-led clinic for voice and swallowing difficulties in two Dublin hospitals showed that approximately 80% of referrals could be managed by advanced practice SLTs, without additional input from ear, nose and throat (ENT)

consultants. This resulted in a significant reduction of wait times (patients seen by SLT for voice and swallowing difficulties within 2–3 weeks compared with an ENT waitlist of 1–3 years).[4] Enabling HSCPs to lead and to carry the responsibility for senior clinical decision-making in such specialist services prioritises their specialist expertise, for the benefit of patients.

In the context of autism, as well as mental health difficulties, the rates of diagnosis are increasing in many regions, especially among young people, while access to appropriate services, including AHP services, is limited and characterised by long waiting lists, especially in public health systems.[8 9] One implication from this is the need to pursue continuing development and expansion of the scope of practice of AHPs, as well as their numbers in health services, and their better integration into the overall healthcare systems.

To maximise the benefit for patients, co-production of healthcare, involving the multiple professional groups involved, as well as patients, is crucial.[10] Co-production requires mutual understanding and respect, and discourses of 'domination' and the disempowerment of professional groups (specifically AHPs, as found by the review of Wilson and colleagues) are counterproductive.

Herein also lies a challenge and an opportunity for education. Education programmes need to expand the scope of interprofessional learning in both theory and clinical practice to break down professional barriers, instil a mutual understanding of roles and respect, and shape professional identities not so much in contrast but in collaboration with each other.

Research into the direct effect on patient safety of enhanced roles of AHPs in MDTs is at present outstanding. However, there are promising initiatives, such as ongoing work on multidisciplinary medication management after stroke, to improve medication adherence and thus decrease the risk of recurrent stroke (as well as to manage other health conditions).[11]

CONCLUSION

The review by Wilson and colleagues is an important contribution to the literature on patient safety in and of itself, in as much as the role of AHPs has not received focused attention in the specific contexts under investigation in the past. However, as well as that, the article serves as a window on wider concerns. While the review focuses on patient safety incidents in inpatient care for very vulnerable people (adult mental health, autism and learning disability), its implications reach much further. The necessary 'cultural shift' referenced by Wilson and colleagues can be brought about through an overall health systems approach: Healthcare education for partnership and collaboration, but also top–down measures relating to enhanced role definitions and opportunities for AHPs/HSCPs to take lead roles in clinical services, which will require significant ongoing health system reform. Patients will benefit from a better understanding of and increased prioritisation of AHP roles by way of better access to specialist AHP services. Additionally, improved MDT dynamics and communication practices, as well as the availability of specialist AHP expertise, have the potential to significantly improve holistic, person-centred care.

Contributors All authors (AER, MMcG, JMcV, NM) contributed to writing the editorial. NM finalised the revisions. NM is the guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Commissioned; internally peer reviewed.

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REFERENCES

1 Wilson C, Wakefield R, Prothero L, *et al*. Developing the allied health professionals workforce within mental health, learning disability and autism inpatient services: rapid review of learning from quality and safety incidents. *BMJ Qual Saf* 2025;34:389–403.
2 Van Dijk T. Critical discourse analysis. In: Schiffrin D, Tannen D, Hamilton HE, eds. *The handbook of discourse analysis*. Oxford, UK: Blackwell, 2001: 352–71.
3 NHS England. Multi-professional framework for advanced practice in England. 2017. Available: https://advanced-practice.hee.nhs.uk/multi-professional-framework-for-advanced-practice/
4 HSE National Health and Social Care Professions Office. *HSCP advanced practice framework*. Dublin: Health Service Executive, 2023.
5 Mannion R, Davies H. Understanding organisational culture for healthcare quality improvement. *BMJ* 2018;363:k4907.
6 Bell S, Garud N, Pati R, *et al*. Happier workers, healthier patients: an analysis of healthcare worker engagement and health service outcomes in Victoria. Research report. Safer Care Victoria and Victorian Managed Insurance Authority; 2022.
7 O Mir M, Cooney C, O'Sullivan C, *et al*. The efficacy of an extended scope physiotherapy clinic in paediatric orthopaedics. *J Child Orthop* 2016;10:169–75.
8 Lynch S, McDonnell T, Leahy D, *et al*. Prevalence of mental health disorders in children and adolescents in the Republic of Ireland: a systematic review. *Ir j psychol Med* 2023;40:51–62.
9 Russell G, Stapley S, Newlove-Delgado T, *et al*. Time trends in autism diagnosis over 20 years: a UK population-based cohort study. *Child Psychol Psychiatry* 2022;63:674–82.
10 NHS England. The allied health professions (AHPs) strategy for England: 2022-2027 AHPs deliver. 2022. Available: https://www.england.nhs.uk/long-read/the-allied-health-professions-ahps-strategy-for-england-ahps-deliver/
11 Bell S, Kelly H, Hennessy E, *et al*. Healthcare professional perspectives on medication challenges in the post-stroke patient. *Front Pharmacol* 2023;14:1266277.