**NES AHP Contribution to Public Health**

Meeting with Laura Cameron, Clinical Informatician, NHS National Services Scotland

10 February 2022

Laura’s remit centres around digital and data collection. Much of her work since being in post has been on the development and implementation of a [national dataset for AHPs (AHPOMs)](https://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/Allied-Health-Professionals-National-Dataset/Operational-Measures.asp). This is a clinical activity dataset, aiming to capture the basic data of who sees AHPs across Scotland, where, why, when and for how long. When collected and analysed at a national level, it is hoped that the data would provide insight into the demand & volume of AHP contacts, allow exploration of variations in service delivery and outcomes, and highlight opportunities for service improvement.

Looking at an AHP dataset for clinical activity started about 10 years ago, with the recognition that we don't know across Scotland who's doing what, which patients are getting seen and for what reasons. It came up in the first AHP Strategy and then it got then picked up in [ALIP](http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4086355/964fa51b-5bb7-4a7a-8225-3d78936a6e14.pdf) and became reinvigorated. One of the delivery items of ALIP was implementing a national clinical activity dataset. Laura came in at the point that the dataset had been consulted on, refined and published (Oct 2017). The focus of the work was then about implementation.

There are 37 items on the dataset and these are the bare bones of patient demographic data, some activity data around patient appointment times, DNAs, CNAs, a rough idea of what the patient is there for e.g. MSK problem or a neurological problem. It would have to cover all of the AHP groups. It's really a minimum dataset in the sense of what do we have to know for all the AHPs to get some clinical activity data and everything be relevant to everyone, with the idea that if some groups or professions need to add to it, then they can do that either at a professional level or at local level. The plan is that the data can be fed up to a national level so we can get an idea of what's going on in Scotland, so we can see where people are doing things differently and better to learn lessons across the whole of Scotland.

National Services Scotland published the dataset in 2017, they have a data mart in place to physically collect all the data, and IG permissions are also in place. Everything is sitting waiting to be able to take the data. However, there is a big problem in that locally the boards aren't able to give the data to National Services Scotland as only approximately 50% of AHPs are collecting their data on electronic systems (estimates based on board-level discussions in 2019). Additionally, sometimes even where data is being collected on electronic systems, there are issues with extracting and delivering it. There are also a lot of issues around holes in the data. Therefore it was felt that it would not be appropriate to receive further funding from Scottish Government to push this forward nationally when what was needed was local work to develop boards’ ability to collect, extract and make sense of the data.

The dataset has been piloted with certain boards that were further ahead with their data collection and dashboards have been drawn up to show what could potentially be done with the data. They know what can be done with the data but the issue has been around the fact that a lot of boards aren't in a position to be able to provide the data. There are a lot of systems in use, multiple systems in each board, let alone across Scotland. Not all professions within AHPS have got access and even within each profession not all individuals have got access.

Data capture needs to be improved at board level. This may be around getting AHPs onto electronic systems in the first place, sorting it out so that they are entering the appropriate data and ensuring it is clean data. Appropriate training needs to be in place. This was left with AHP Directors Scotland Group (ADSG) in summer 2019 to consider how they might help move this forward at a board level. Work at the National Services Scotland level has been paused but they are ready to take the data once it is ready, although the project team would need to be stood up again.

Over COVID, there's been a lot of questions asked about activity that had the dataset been in place, could have been answered e.g. “How many video consultations do AHPs hold across Scotland?” The dataset has been mentioned in other conversations around about workforce as we need activity data to be able to compare and contrast alongside workforce data and outcomes data to be able to know what impact AHPs are having on the population’s health and care as a whole.

**AHPOMs and Public Health**

The dataset can't collect any universal data as it is based around CHI numbers; everything has to be associated with an actual person. There is no way no way within the dataset of collecting delivery of public health sessions for example, which a lot of AHPs do out in the wider community. That is something that the team is well aware of but they need a solution as to how to capture that data when it is not associated with an actual person. The fact that the dataset cannot capture public health work has been consistently highlighted along the way. It is recognised that this is one of the parts of an AHPs role that the dataset does not serve and there is a need for future development.

**Laura’s own ideas on capturing public health activity**

Diary capture where activity is pulled directly out of people’s scheduling systems in their diaries is a potential solution but everyone would have to name it the same thing and record it appropriately. Rules would have to be set around what it was called, how you recorded the number of people that were involved and the number of staff involved.

Develop a universal CHI number - is there a way we can attribute public health activity to a specific CHI number which is only used for a non-named person? It would only be used for that sole purpose. However, Laura is unsure if this is feasible or would be allowed as a CHI number is a certain thing and it might not be able to be anything else. This is not something that she has investigated in any way, shape or form. In addition, using CHI in this way may open the floodgates to other less appropriate uses, and thus we may not want to even consider this.

The only other way is a large system overhaul, to have a system of capturing activity that is not attributed to CHI and Laura doesn’t know how you do that either. It would probably be a massive job.

**Further input**

Laura consented to being contacted again for further involvement in this work if appropriate [laura.cameron@nhs.scot](mailto:laura.cameron@nhs.scot)

**Sheila Wilson**

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