AHPF contribution to Health Select Committee Inquiry on STPs (letter from the Chair)

Evidence from the Allied Health Professions Federation

Thank you for the opportunity to submit written evidence. The Allied Health Professions Federation has a number of key concerns re STPs in relation to the questions being addressed by the inquiry.

Summary of points

- The AHPF shared the ambitious goals of the STPs to make systems more rehabilitation and preventative.
- Achieving these goals will rely on taking a more biopsychosocial model of care, in which Allied Health Professions (AHPs) are experts.
- The AHPF is concerned that the focus on community rehabilitation, primary care and prevention within the strategic goals of STPs are not being translated into action and there is a continued dominance of a narrow medical model.
- The expertise of AHPs should be drawn on in the further development of STP plans. This requires better communication on how AHPs can get involved in STP work streams – both as leaders and as engaged teams.
- To ensure that the AHP workforce is in place to deliver a transformed system of care, workforce supply and retention issues need to be addressed.

How effective have STPs been in joining up health and social care across their footprints, and in engaging parts of the system outside the acute healthcare sector, for example primary care, local authorities, public health, mental health and voluntary sector partners?

1.1 Allied Health Professions (AHPs) have a key role to play in supporting and delivering STPs. There are 158,000 working in a range of settings including hospitals, people's homes, community clinics, GP surgeries, the justice system, local authorities, private and voluntary sectors and primary, secondary and tertiary education. As such, they have wide knowledge and experience of local needs and a unique overview of entire patient pathways.

1.2 The contribution of AHPs is in the NHS 5 Year Forward View and the recent AHPs into Action strategy (https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf). However, their potential contribution to STPs is over-looked in many areas and AHPs have found it difficult to get involved in local Boards and activity.

1.3 AHPs need to be encouraged and actively involved in the design and delivery of STPs and within leadership roles within STPs; for example none of the clinical STP leads are from AHPs. Most people get into the top posts in the NHS through clinical directorships and therefore have to be a medic or a nurse. This is a barrier and we see it as discriminatory towards AHPs. We have asked the Secretary of State for Health and Social Care and the Faculty of Medical Leadership and Management (FMLM) who are reviewing how to increase the number of clinical professionals moving into senior management positions in the NHS, to remove this barrier for AHPs. The primary function is not to 'represent' individual AHPs on Boards but to bring a different perspective based on their biopsychosocial model of care. This will support effective Trust strategy and good governance, multi-professional partnership working and challenging traditional medical thinking.

1.4 Local buy-in among staff and the public for STPs is essential. The Royal College of Speech and Language Therapists (RCSLT) found in a survey last year, that only around 10% of their members had been engaged in

any way about the development of their STP. In addition, the process is opaque and in each locality there is no clear contact point apart from the STP leader. Information about how to feed into particular work streams needs to be made available.

1.5 Many STPs have ambitions to develop a more rehabilitative and balanced system of care including reshaping community based services in hubs around GPs. However in practice there continues to be an over-reliance on traditional models of care, with many people still being admitted into hospital for entirely preventable causes, and most of the STPs lack detail on rehabilitation services outside hospital. This needs to be addressed. AHP clinicians focus on early intervention and rehabilitation that supports people to live healthily in their own home. As such, AHPs have many examples of innovation that could provide a blueprint for sustainable change, both in specialist rehabilitation to support early discharge and community rehabilitation that maximises return to health and minimises lasting disability.

1.6 An example of this is ESCAPE-pain – a programme that provides group rehab for people with osteoarthritis has had a significant lasting impact in reducing reliance on health care services and medication.

1.7 Another example is Hope Specialist Service, a social enterprise in Grimsby, which combined two hospital based rehab services for patients with Chronic Obstructive Pulmonary Disease (COPD) and older people at risk of falls. Taking two hospital based rehabilitation services for COPD and moved it out into the community. The multi-disciplinary rehabilitation team includes 80 volunteers. The volunteers are former patients and carers, who act as motivators, role models and community educators. Together they have transformed a run down former GP surgery into a modern rehabilitation centre, with a gym, garden and café, creating a valuable community asset. They have prevented hospital admissions (one per patient on the programme saving £2600 each); reduced numbers of hip fractures, and achieved a quit smoking rate 62% higher quit rate than the national average. Patients report significantly reduced levels of anxiety and depression with higher confidence and ability to undertake daily activity.

1.8 The 12 professions within the AHPF are currently working together to develop a model for good community rehabilitation, and seeking to engage with STPs to support a greater focus on rehabilitation services that get people out of hospital quicker, prevent readmissions and prevent admissions in the first place.

Looking across all STPs, are there any major areas where the content of the plans needs to be tested for credibility and realism? Is the workforce available to enable the implementation of STPs? Or is the timescale for the changes proposed in STPs realistic?

2.1 The HEE's recently published draft workforce strategy (https://www.hee.nhs.uk) highlights the contribution that AHPs currently make and could make to deliver a sustainable future NHS service if workforce supply, vacancies and retention issues are tackled. It acknowledges this will require; "…focussed AHP leadership in national bodies, local systems and organisation". AHPs will be responding to this consultation, but this underlines the need for effective workforce development for AHPs to help support STPs develop and deliver.

2.2 Prevention has been recognised as a key priority for the NHS, public health and social care and while all STPs have included ambitions to improve prevention, there is inconsistency as to the scale of that ambition and how much is truly committed to it. A survey of Directors of Public Health by the Faculty of Public Health in early 2017 reported; "a failure to tackle the wider determinants of health" within STPs and limitations caused "by the year-on-year budget cuts to the public health budget"

(http://www.fph.org.uk/uploads/170320%20STP%20QUESTIONNAIRE&20final%20-20RA%202.pdf). This concern is reinforced by the NHS Providers 2016 survey which showed; "Investing in more preventative ways of working", to be the lowest ranked issue in terms of importance by respondents. (http://nhsproviders.org/media/2461/state-of-the-provider-sector-survey-briefing-final.pdf).

2.3 At a time when the NHS is seeking to transform its services, AHPs offer innovative practice and experience to meet the challenges of changing care needs at local and a national level. AHPs produce financial savings for NHS services and improved outcomes for patients. AHPs can lead integration partnership working across health, care, housing and education sector and act as the first point of contact for patients with complex conditions. However, without a clear pathway to be involved in the leadership and delivery of STP goals, this potential contribution risks being marginalised.

Finally the AHP CEOS and I would be very happy to talk to the Inquiry and give further evidence of these points above and what else could be achieved by STPs and AHPs working together more effectively.

Yours sincerely,

Parmjit Dhanda

Chair, AHPF

Annex: The AHPF

The Allied Health Professions Federation (AHPF) is made up of twelve professional bodies representing Allied Health Professionals (AHPs). The AHPF provides collective leadership and representation on common issues that impact on its members' professions:

- The Association for Music Therapy (BAMT)
- The British Association of Art Therapists (BAAT)
- British Association of Dramatherapists (BADth)
- The British Dietetic Association (BDA)
- British Association of Prosthetists and Orthotists (BAPO)
- British and Irish Orthoptic Society (BIOS)
- Royal College of Occupational Therapists (RCOT)
- Chartered Society of Physiotherapy (CSP)
- The College of Paramedics (CoP)
- Royal College of Speech and Language Therapists (RCSLT)
- Society and College of Radiographers (SCoR)
- The Society of Chiropodists and Podiatrists (SCP)

There are 158,000 AHPs working within a range of surroundings including hospitals, people's homes, clinics, surgeries, the justice system, local authorities, private and voluntary sectors and primary, secondary and tertiary education.

AHPs focus on consistent, person-centred, preventative and therapeutic care for children and adults. They are accredited and trustworthy professionals performing a crucial function in the NHS and social care. The breadth and depth of AHP skills and reach make them ideally placed to lead and support transformative changes.