The Rt. Hon Jeremy Hunt MP
Chair, Health and Social Care Committee

8 May 2020

Dear Mr Hunt

The Allied Health Professions Federation's response to the Committee's request for evidence to the Inquiry on Delivering Core NHS and Care Services during the Pandemic and Beyond

The Allied Health Professions Federation (AHPF) is delighted to respond to the Committee's request for evidence. The AHPF is made up of twelve professional bodies representing Allied Health Professionals (AHPs). We provide collective leadership and representation on common issues that impact on AHPs. A full list of member organisations and some further information about the Federation is in the Annex at the end.

AHPs are the third largest workforce in the NHS after doctors and nurses. There are over 150,000 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. As such, there are many AHPs currently working in critical care, supporting and helping patients manage and recover from COVID-19, as well as a high proportion of returners to these professions and final year students volunteering to work. AHPs are also working in community settings or in peoples' homes ensuring successful discharge from hospital, rehabilitation and community based rapid response services. Furthermore, the NHS has subcontracted AHP services in some areas to social enterprises or private providers.

How to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand

The AHPF believes the challenges moving forward are:

- **Balancing** – Managers need to manage the backlog of existing and new people without COVID19, as well as additional COVID-19 referrals. This will become more critical as planned, elective and urgent care restarts creating extra demands across the entire healthcare system, including acute care, cancer treatment, mental health and community rehabilitation services.
- **Complexity of need** – Patients post COVID19 are presenting with a range of very complex needs and all health professionals, will need to understand patient management, recovery timeframes, and flags for risks and deterioration.
- **New ways of working**: Services need the skills, confidence, resources and permission to engage in telehealth to keep children and adults safe and in their home, including supporting their communication and swallowing needs.
- **Planning**: managers need to be flexible to support and manage non-COVID and COVID patients in the community and acute settings, as well as planning for a possible second wave of the pandemic which may require additional staff support to respond to an influx of acute cases, additional staff illness and further social restrictions.

Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak

During the pandemic, community and many outpatient health services have been scaled back. For example, many people (including children and young people, adults and older people), who would normally receive speech and language therapy in the community, did not receive any intervention for speech, language and communication support as their needs were not classed as "urgent". 49% of Speech and Language Therapists reported that patients/clients are seen less frequently. Furthermore, 81% said that there were clients on their caseload who were no longer receiving an intervention but who would usually do so.

Diagnostic services will face challenges in terms of all of April's patients coming with May's workload, as elective work starts again. Diagnostics are likely to be bottleneck unless there is appropriate investment in service planning and an appreciation of the already stretched nature of the services pre-Covid 19 and the impact on the workforce.

The pandemic is shining a light on the poor state of community rehabilitation provision. While there are many excellent services, access to rehabilitation is a postcode lottery, and for decades services have been under-resourced and under-developed. Planning and commissioning is inconsistent, and there is significant variation in standards.

These issues could be tackled by;

- The transformation work and relevant project streams in the NHS Long Term Plan should be progressed, and reviewed through a Covid-19 lens
- Promoting and facilitating continued collaboration between NHS, social care and voluntary sector providers (for example through pooled funding) to coordinate a tiered response that enables people to be supported by the right professionals, in the right setting, at the right time
- Applying a similarly tiered approach to ensure that specialist services are available to those with the most complex needs, and that targeted and universal resources are available to people whose needs are more straightforward and those who can self-manage
- Implementing the NHS Rightcare Community Rehabilitation toolkit and training and retaining an expanded multi-disciplinary rehabilitation workforce
- Funding research into the efficacy of therapy approaches to understand if / when remote approaches can be used to facilitate positive rehabilitation outcomes. Remote service delivery will increase the number of people who can be supported, but this should not be at the expense of the quality of outcomes
- Funding projects to develop and track outcomes of therapeutic self-management tools

Meeting extra demand for mental health services as a result of the societal and economic impacts of lockdown Mental Health

AHPs make an important contribution to mental health services. For example, speech and language therapists and occupational therapists provide person-centred care to both children and adults as part of a multi-disciplinary mental health team, helping to identify and support the individual's needs, and enabling them to be involved in decisions about their care.

Arts therapies, including music, drama and therapy are established psychological clinical interventions, which are delivered by HCPC registered Music, Drama and Art Therapists, to help people of all ages, including children, adolescents, adults and the elderly - whose lives have been affected by injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs. Arts therapies should be integral to any mental health team enhancing its holistic support and treatment for anyone who requires it. During and post the Covid-19 pandemic, these therapies could be utilised to provide people with existing mental health issues more support and immediate support to those affected by Covid-19, including frontline and other health and social care staff, survivors and the bereaved. Many arts therapists are skilled and experienced in working with people affected by trauma, bereavement and long-term health issues all of which could be utilised during and after the pandemic. Arts Therapists are already delivering online and phone-based support and debrief for staff and for volunteers who provide support to people with severe mental health problems in challenging circumstances.

Patients with eating disorders will have been particularly hard hit by both the lockdown and the restrictions and changes to food shopping. Many will have been less able to access support from dietitians and other therapists, or access community support. Beat, the eating disorders charity, has reported a 35% increase in calls to their helpline during the pandemic.

The suggestions for managing the wave of pent up demand above, could be applied to these issues too.

Meeting the needs of rapidly discharged hospital patients with a higher level of complexity

AHPs are reporting that people who received acute or intensive care treatment for COVID-19 may suffer from a whole range of associated problems lasting for months or even years. The consequences of life saving interventions such as sedatives, mechanical ventilation, intubation, oxygen therapies and tracheostomy may lead to countless longer term problems.

Early access to rehabilitation services should be based on level of need rather than condition, using triage to prioritise high, medium and low risk cases.

It is becoming clear that people recovering from Covid-19 with significant and complex rehabilitation are being discharged from hospital to home without on-going rehabilitation support in place. Currently there are insufficient step down rehabilitation facilities. The announcement on 4 May 2020 of the new Mary Seacole rehabilitation centre in Surrey, to be followed by other services across the country is extremely welcome. It is critical that these are set up quickly and remain in place for as long as they are needed, and are integrated with community provision.

Before the crisis there was insufficient capacity in inpatient rehabilitation – for example for people who have had a stroke, have a head or spinal injury – who are not yet well enough to return home. Much of this capacity is needed post pandemic.

Rehabilitation services, including those in the community, were already overstretched before the pandemic, and as such are not currently equipped to meet the needs of patients - Covid-19 and non-Covid - who are being rapidly discharged from intensive care and acute hospitals.

Staff who ordinarily work in community-based rehabilitation services have in many areas been redeployed to work in the acute sector. As workforce needs in the acute sector have not been as great as anticipated or are diminishing, many of these staff are currently working in the acute sector but are underutilised.

The national temporary staffing register includes many rehabilitation workers made up of clinicians returning to practice, students, and clinicians from the private sector. However, many people who have stepped up to register to play their part are still waiting to be deployed. At the same time, many managers in the community have no way of accessing staff from this register.

Rehabilitation will also be a key issue for systems planning. This includes addressing how systems are planning to meet the rehabilitation needs of Covid19 survivors and the build-up of rehabilitation needs among the population more broadly. There are people who have had COVID-19 for whom AHPs are developing a novel rehabilitation pathway. It will also be important to consider how existing community rehabilitation services have been maintained and how systems are retaining, training, and expanding the multi-disciplinary and multi-sector rehabilitation workforce. National stakeholders will need to work with professional bodies, patient groups and researchers to collect and apply evidence on rehabilitation needs.

Planning could include;

- The NHS Discharge to Assess model could be used to ensure clear pathways, communication and operating procedures between acute, community and local authority services and remove barriers to collaborative working (for example, separate funding pools).
- A national strategic approach to Covid-19 rehabilitation, based on an assessment of demand and capacity and agreed pathways, such as that proposed by the British Society of Rehabilitation Medicine
- Agreement on common rehabilitation needs assessment framework and outcomes tools for people recovering from Covid19
- Building up multi-disciplinary community rehabilitation teams with the skills and staff required, with access to input from rehabilitation, elderly care and psychiatric medics in secondary care
- Moving the redeployed workforce back into the community – including the temporary workforce
- Following through with commitments to increase inpatient rehabilitation capacity, and ensuring that this is maintained post crisis to meet needs
- Promotion of online management systems for use in the community and telehealth as an integrated part of rehabilitation services

Providing healthcare to vulnerable groups who are shielding

There is a need to guarantee adequate supply of appropriate PPE to all community health, social care and non-statutory healthcare providers and clearer guidance about use of PPE in the community, for example, donning and doffing.

How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise

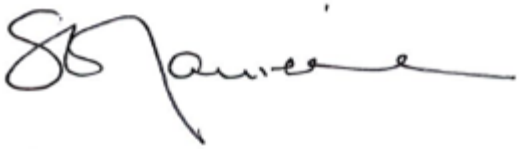
There are opportunities to re-design care pathways to maximise patient outcomes and experience. This includes consideration of the following:

1. Addressing health inequalities
2. Services co-produced with patients, carers and service user organisations (in line with the NHS personalisation agenda)
3. Ensuring that best practice experiences are shared nationally, so that settings can learn from the experiences of others, and provide relevant implementation tools and resources
4. Establishment of 'one-stop MDT (Multi-Disciplinary Teams) follow-up clinics to support holistic approaches to care and maximising the skills of the workforce e.g. AHP-led clinics
5. There are existing services – adult and children, acute and community – which will have to be reprioritised
6. More pooled funding across settings to reduce barriers and delays commonly faced when patients transition between acute and community / social care services
7. Continued provision of communications software (e.g. Microsoft Teams, NHSmail) to whole health and care sector – including social care, care homes, hospices and other non-statutory providers, to facilitate effective communication across settings
8. Promotion and use of telehealth - digital prescriptions/therapy resources and platforms, telephone screening. There are changes to practice and service delivery such as teleworking resulting from the outbreak which may continue – and some may be improvements

Many of these have been developed quickly and in a spirit of good will and alongside a reduction in other pressures. They can only be continued and imbedded if services receive sufficient time and resourcing. It is also apparent that positive changes have not occurred everywhere, and it will be important to scale up and expand good practice where it exists. This has always proved to be a challenge and will be even more so during a post-COVID recovery period.

AHPF Board members and I would be very happy to meet the Committee (virtually of course), to explain these points further.

Yours sincerely



Steve Jamieson
Chair. AHPF

Annex: The AHPF

The AHPF's Vision is that; "The AHP workforce is positioned to improve the health and well-being of the population". Our mission is; The Federation provides collective AHP leadership and representation to influence national policy and guidance at a strategic level". In all areas, the AHPF promotes parity between mental and physical health.

The Allied Health Professions Federation (AHPF) is made up of twelve professional bodies representing Allied Health Professionals (AHPs):

- 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)
- The College of Podiatry (CoP)
- Royal College of Speech and Language Therapists (RCSLT)
- Society and College of Radiographers (SCoR)

AHPs are the 3rd largest workforce in the NHS (after doctors and nurses) and deliver high quality services across health and social care. There are over 150,000 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 registered, regulated 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.