Health and Social Care Select Committee Inquiry: Delivering core NHS and care services during the pandemic and beyond

This is a joint response submitted by 22 professional bodies and charities (see end).

Key points

- In this submission we have interpreted 'core NHS and care services' as both those relating to Covid-19 recovery and non-Covid
- Rehabilitation is an unmissable stage in the Covid-19 trajectory and recovery. But many survivors are being discharged without this in place.
- Services that support rehabilitation for people across a range of conditions are key to getting the country back on its feet and back to work beyond the pandemic
- Learning from the pandemic needs to be used to shape rehabilitation services for the future and address the weakness of this under-developed part in the current healthcare system

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

1.1 The healthcare system has rightly focused on saving lives and stopping the spread of the virus, and has been effective. In the second phase, we need to focus on supporting people to recover from Covid19, to regain health and independence as fully as possible and participate meaningfully in their communities.

Identifying Covid-19 patients' needs

1.2 Covid-19 patients are being discharged from hospital with complex and varying rehabilitation needs, as a result of the virus itself and as a consequence of time spent in critical care.

1.3 These include: cardiorespiratory problems, resulting in increased breathlessness, high levels of fatigue; neurological sequelae and neuromuscular bed-rest related deconditioning. The most severely affected are those living with frailty and those with pre-existing long-term conditions or multi-morbidity. (1) People are reporting psychological issues, including: anxiety and depression, cognitive impairment and post-traumatic stress disorder. (2)

1.4 Further research is required, in particular on the neurological responses - including stroke-like events and hypoxic brain injury and peripheral neuromyopathy. These will have implications for rehabilitation needs.

Rehabilitation to support recovery

1.5 Rehabilitation is the process of assessment, treatment and management with ongoing evaluation whereby an individual is supported to reach their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living. (3)

1.6 The key components of rehabilitation - a patient-centred approach, goal setting and shared decision-making - remain the same for Covid-19 survivors. All decisions about care, including rehabilitation, must be based on clinical need, presenting signs and symptoms, and individual circumstances. They should not be based on age.

1.7 Rehabilitation needs to empower people to recover and build up resilience at their own pace and be underpinned by research. Education is key to building an individual's confidence to self-manage and can supplement direct input by healthcare professionals.

1.8 People recovering from Covid19 will need interventions that address the decline in strength and function, and focus on the major symptoms (mental and physical) and multiple systems in the body that are affected.

1.9 Covid19 patients require specialist rehabilitation while in intensive care and will recover more quickly and fully if they have rehabilitation that begins in the acute setting and continues seamlessly during and after care transitions, without gaps. (4)

1.10 On discharge they will have different levels of rehabilitation needs. Using the categories set out in the NHS England Discharge to Assess Guidance (5), researchers have carried out an audit of a number of London hospitals (6). This suggests the proportions of ICU patients in London requiring these categories of support on discharge (table 1).

Category	Requirement	% of patients
1	Those who with assessment, tailored advice and tools, can self-manage and take the steps they need to aid recovery	21% to 33%
2	Those who can be discharged from hospital to home with support and individually tailored home based rehabilitation, from a multi-disciplinary rehabilitation team	30% to 49%
3	Those who are medically stable and need to be discharged from ICU to spend a few weeks in a step-down (residential) or bed based rehabilitation centre or ward	12% to 22%
4	Those who continue to require 24/7 specialist medical input to support specialist rehabilitation and/or tracheostomy weaning	2% to 21%

Table 1

1.11 Many people's recovery progress will be improved when this takes place in familiar home surroundings (7), but only if their rehabilitation continues to be coordinated and supported, along with appropriate social care in place (category 2 table 1).

1.12 The numbers of medically stable people being discharged from ICU who require some time in step-down care (category 3, table 1) is likely to be higher than normal. This is because of the complexity of needs, the disruption to people's normal support structures in their homes and disruption to community rehabilitation and other services.

1.13 Rehabilitation for patients in category 3 should be in environments focused on recovery, staffed by multi-disciplinary teams who are equipped to continue to support people with their recovery after they have returned home.

Needs are not being met

1.14 It is becoming clear that many people recovering from Covid-19 with significant and complex rehabilitation needs are being discharged from hospital to home without on-going rehabilitation support in place.

1.15 There are also 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.

1.16 It is critical that these are set up quickly and remain in place for as long as they are needed, integrated with community provision.

Providing the right workforce

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

1.18 Many clinicians 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, some of these clinicians are now underutilised.

1.19 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 registered 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.

Joined up planning and consistent guidance

1.20 While there are some excellent examples of regional and local responses and pathway development, overall planning and guidance on Covid-19-related rehabilitation appears inconsistent and disjointed.

1.21 In acute sector there is a short-term focus on discharge planning to ensure immediate patient safety, and not always enabling recovery, so discharges are happening without community rehabilitation in place.

1.22 In parallel, NHS England are requiring General Practice and Primary Care Networks to stratify the ongoing care needs of people recovering from Covid-19, but rehabilitation is not specified as a need.

What should be done?

1.23 As the system focused on building up intensive care capacity, now it must plan how to meet the rehabilitation needs of patients following discharge with the same sense of urgency.

1.24 We propose the following priorities:

- 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 (8))
- Integrated Care Systems should carry out audits of rehabilitation needs to stratify patients being discharged from intensive care, map existing provision and plan to meet gaps
- Agreement on common rehabilitation needs assessment framework and outcomes tools for people recovering from Covid19, such as the rehabilitation prescription developed by the UKROC (8)
- 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 and community care
- Redeploy the workforce back into the community – including the temporary workforce
- Deliver commitments to increase step-down rehabilitation capacity

2. Providing healthcare to vulnerable groups who are shielding and how to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand

2.1 Throughout the pandemic, people are still having falls and fractures, strokes, heart attacks, preparing for cancer treatment or recovering from it, having accidents and illnesses that result in spinal cord and brain injuries and having exacerbations and acute episodes related to long term conditions, including cardiovascular, respiratory, musculoskeletal, rheumatology and neurological.

2.2 In all these situations, early, timely and sufficiently intensive rehabilitation will often be critical to people's long-term recovery and the level of wellbeing and independence people regain or maintain. For older people timely rehabilitation is key to support people to prevent decline, optimise independence, prevent hospital admissions and the need for long-term care. Rehabilitation enables people (including key workers) to return to work and participate in society after lockdown.

2.3 During the pandemic, some essential and time-urgent elements of rehabilitation have continued, while supporting shielding and social distancing.

2.4 For example, many services have started to provide virtual consultations and are providing digital exercise programmes as an alternative to group classes. These could be a more prominent feature of rehabilitation services beyond the pandemic (see 4.6).

2.5 For many of the most vulnerable groups, rehabilitation can only take place and be effective if it is face–to-face – whether this is in hospitals, care homes or in people's own homes. Many older people, particularly those with cognitive impairment, will not be able to use video-consultations. Some services that were previously provided from outpatient centres may now need to be provided within individual's homes.

2.6 As community rehabilitation services resume normal levels of service, it will be important to provide the care required while maintaining shielding for vulnerable groups.

What should be done?

2.7 Local managers need consistent advice and time to assess when rehabilitation interventions are essential and on how community rehabilitation can recommence fully.

2.8 As services recommence, there should be a positive risk approach, supporting ongoing guidance on social distancing, testing for professionals and carers, PPE at the appropriate level, and prioritisation on the phasing in of aspects of services.

2.9 To support shielding, there needs to be national support and guidance for provision of more telehealth and digital rehabilitation options where appropriate, and moving more face-to-face rehabilitation from outpatients centres to home - including as alternatives to clinic-based appointments and services. Professional bodies will have a critical role to play in providing guidance on how practice might be adapted.

2.10 Staff delivering rehabilitation services face-to-face must have the appropriate levels of PPE to enable this to happen while shielding the most vulnerable and stopping the spread of the virus.

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

3.1 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, with services being under-resourced and under-developed for decades. Planning and commissioning is inconsistent, and there is significant variation in standards.

3.2 This weakness in our current system already undermines efforts to transform the NHS and social care to be more preventative and proactive. Meeting the scale of rehabilitation need - both covid and non-covid related – beyond the pandemic will require the rehabilitation offer to be expanded and modernised (below).

3.3 Planning for this needs to start with training and retaining an expanded rehabilitation workforce to deliver expanded high quality, multi condition community rehabilitation, implementing the NHS Rightcare Community Rehabilitation toolkit (9).

3.4 In addition to under-resourced community rehabilitation, 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.

3.5 The NHS Long Term plan (10) commits to improvements to the care of patients across a number of clinical priorities, and to improve and achieve integration of primary and community care.

3.6 With a tidal wave of rehabilitation needs on the horizon as the UK recovers from the pandemic, progressing the ambitions of the Long Term Plan to transform the health care system to meet future population needs could not be more important.

3.7 Covid-19 has also illustrated starkly the link between social-economic circumstances on levels of ill-health and disability (including learning disability), as well as having a disproportionate impact on people from black and ethnic minority communities. The pandemic will most likely increase health inequality.

3.8 Radically improving and expanding access to rehabilitation, as an essential part of healthcare is fundamental to redressing health inequality.

3.9 The roll out of First Contact Practitioners in primary care (in the Long Term Plan) to improve musculoskeletal health services must be

progressed, and will be an important referral route into community rehabilitation services.

Impact of lockdown on mental health

3.10 Among the older population and vulnerable groups, such as people with learning difficulties, there was already an unmet need for support with anxiety and depression. Current isolation because of lockdown and shielding will lead to an increased need for services in the coming months.

3.11 There is anecdotal evidence of fewer admissions to acute mental health adult wards, including people with dementia and older people with serious mental illness. We need to understand what has driven this and the consequences of people remaining in the community who would otherwise have been in acute mental health wards.

3.12 People with a variety of mental and physical conditions who normally access day centres and respite care are not being able to, which will be a significant cause of stress among carers.

What should be done?

3.13 Plan to expand both community rehabilitation provision and, where necessary, retain planned additional capacity for step-down (bedded) rehabilitation units.

3.14 Progress the transformation work and relevant project streams in the NHS Long Term Plan (LTP), and review these through a Covid-19 lens. Establish rehabilitation as a cross-cutting theme, with a national rehabilitation lead.

3.15 Ensure mental health organisations and services are part of integrated care pathways for all the populations referred to in this response.

3.16 Factor in access to rehabilitation into strategies to tackle health inequality.

3.17 Through the forthcoming NHS People Plan, deliver an expanded rehabilitation workforce, including allied health professionals[i] with advanced practice skills, support workers and care assistant trained to add capacity, sports and exercise professionals, postural stability instructors, coaches working in the voluntary sector and rehabilitation medicine doctors.

3.18 A commitment to quality rehabilitation as an integral part of the healthcare system to be reflected in the NHS Mandate and NHS Constitution as these are reviewed by Parliament. (11)

4. 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.

4.1 To meet the scale of need, rehabilitation needs to evolve. The experience of the pandemic provides important learning for this.

What should be done?

4.2 Because Covid-19 is a multi-systemic condition, with significant physical and mental health consequences, it illustrates very well the continued importance of shifting an approach to rehabilitation away from one that is based on neat medical specialisms and condition silos.

4.3 The experience of Covid-19 recovery should provide an impetus to adopting a personalized, multi-condition, biopsychosocial approach that can respond to the needs of increasing numbers of people having multiple conditions impacted by multiple factors.

4.4 This approach needs to support greater inclusion of vulnerable and hard-to-reach groups, who have the worst health outcomes and experience barriers to services. This includes people with learning difficulties, dementia and serious mental illness. Services need to make reasonable adjustments to make them accessible – for example, adapting communication.

4.5 A consequence of a more social, public health orientated approach to rehabilitation could mean more extended rehabilitation located in communities, moving from out-patient departments to facilities like leisure centres. This should be underpinned by research and evaluation to determine what works for whom and when.

4.5 Responding to Covid-19 has required an expansion of NHS staff. Many of these will not be able to stay in the workforce – such as the students who need to return to their studies. However, many will want to stay, providing a head start towards the necessary expansion of the rehabilitation workforce. There could also be mentoring / training provided by the existing rehabilitation workforce to other practitioners.

4.6 The pandemic has necessitated a shift at scale to online management systems in the community and tele-health (12). As services get back to normal, it is highly likely, this could be continued to make this a much more prominent option for people in how they access and receive services. This must be appropriate, evidence based and result in increase choice and access, not in greater marginalization of some groups and increased health inequality.

4.7 Similarly the development of self-care hubs in response to the pandemic, has reinforced the importance of and increased public

awareness of self-care tools and programmes, which have an important role to play in recovery and rehabilitation. (13).

4.8 In the response to Covid19 there have been examples of barriers between organisations and sectors breaking down (14), including through use of digital platforms, providing a potential impetus to speed up integration.

4.9 Learning from the experience of the pandemic should be captured by robust research and shared so that evidence underpins the future shape of rehabilitation. These should include the perceptions of the patients, staff and carers as well as their clinical effectiveness.

END

The following organisations are jointly submitting this response:

Adult Cerebral Palsy Hub, Age UK, AGILE, Arthritis and Musculoskeletal Alliance, Association of Chartered Physiotherapists in Cardiovascular Rehabilitation, Association of Chartered Physiotherapists in Neurology, Association of Chartered Physiotherapists in Respiratory Care, British Geriatrics Society, British Society of Rehabilitation Medicine, Chartered Society of Physiotherapy, Independent Neurorehabilitation Providers Alliance, Neurological Alliance, Northern Care Alliance, Rehabilitation Workers Professional Network, Royal College of Occupational Therapists, Royal College of Psychiatrists, Royal College of Speech and Language Therapists, Spinal Injuries Association, Society of Research in Rehabilitation, Sue Ryder, UK Acquired Brain Injury Forum, Versus Arthritis.

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