British Association for Music Therapy
British Association of Art Therapists
British Association of Dramatherapists
British Association and Royal College of Occupational Therapists
The British Dietetic Association
British Association of Prosthetists and Orthotists
British and Irish Orthoptic Society
Chartered Society of Physiotherapy
Royal College of Paramedics
Royal College of Speech and Language Therapists
Society of Chiropodists and Podiatrists
Society and College of Radiographers

9th December 2024

To: Cabinet Secretary for Health and Social Care

CabSecHSC@gov.scot

Re: Allied Health Professionals: Driving Transformation in Health and Care

Dear Cabinet Secretary,

On behalf of AHPFS, I would like to thank you for your time earlier in October and for a productive and informative meeting.

At the meeting, we highlighted AHPs' offer in reforming the NHS and delivering Scottish Government's current priorities:

- AHPs are at the forefront of transformation in health and social care especially around early intervention and prevention,
- AHPs rehabilitate people, enabling individuals to maximise their economic activity.

While AHPs have the necessary skills to play a key role in addressing the issues facing NHS Scotland and population health, the factors outlined are restricting their vital contribution:

- AHPs require parity with nursing and medical colleagues, particularly at senior decision-making roles within Scottish Government, Health Boards and Integrated Joint boards.
- AHP Education and Workforce Review necessitates the same focus as the nursing and midwifery taskforce to ensure progress is made to address AHP workforce crisis in a timely and effective manner.
- Wider access to training, such as Earn as You Learn and apprenticeship models, is required to address workforce shortages, particularly in rural and island areas, and to increase attractiveness of the AHP professions.

To further inform the Minister on the issues discussed and allow progression, AHPFS agreed to the following actions:

- Case studies demonstrating the difference AHPs make as well as examples of transformation led by AHPs *(Annex 1)*
- Visits to AHP services. AHPFS are currently identifying areas where you will be able to visit a variety of AHP services in one site to maximise the visit. If your office could contact Sasha Flint, AHPFS secretariat admin.ahpfs@ahpf.org.uk with possible dates, Sasha will coordinate the visit.
- AHPFS has submitted FOI requests in respect of membership of the primary care steering group and AHP representation on health boards and IJBs and will contact you again once we have obtained the full information.

Once again, thank you for your time and support for the Allied Health Professions. We look forward to our continued collaboration in achieving a healthier, wealthier population through prevention, early intervention and rehabilitation.

Yours sincerely,

Hilary Munro
Chair of Allied Health Professions Federation Scotland (AHPFS)

Annex 1

Reducing Delayed Discharges

Current Case Examples:

Discharge Facilitation

An increased length of stay within an acute hospital can have a detrimental effect on a patient's mental, emotional and physical health, mobility, independence, function and family with an increased chance of readmission.

Physiotherapists have a key role in supporting and facilitating timely discharge of patients from our acute hospitals to home or a homely setting which in turn helps to reduce length of stay and pressure on an already stretched home care service. Within the ward setting, physiotherapists, along with the multi-disciplinary team, work with the patient to improve balance, transfers, mobility and facilitate independence.

A physiotherapist's role in discharge is multi-faceted and can include early goal setting and agreeing with the patient and their families a functional goal for discharge, making discharge recommendations (e.g. single level living for a fixed period) and facilitating onward referral to community teams. The earlier in the patient's hospital stay these conversations happen, the less likely the patient will have an unplanned extended hospital stay. Physiotherapists are key to ensuring patient needs are identified and addressed as early as possible.

Paediatric Complex Respiratory Team

Following a run of hospital admissions of neurorespiratory patients, the Paediatric Complex respiratory team at NHS Lanarkshire changed their way of working.

To reduce hospital admissions the team assessed the respiratory risk factors of the neurorespiratory caseload to enable proactive management of these patients at home.

Nurses and physiotherapists assessed all patients using a screening tool developed by Glasgow Children's Hospital, to score respiratory risk factors contributing to recurrent hospital admissions. With the identification of the 10 most at-risk patients, a nurse and physio conducted regular home visits, up to fortnightly.

These visits enabled identification of risks not seen in clinic visits and to optimise medication doses for respiratory risk factors like GOR, hypersalivation, optimise airway clearance, and provide antibiotics where required. Engagement with other MDT members was carried out as appropriate.

Comparison of this patient group the year before this change to a year after demonstrated an 80% drop in admissions and bed days of the ten patients across the year. This was most striking over winter; only one patient of the ten was admitted for one night across November to February and patient feedback was unanimously positive.

The backbone of orthotics

Natasha suffered multiple level fractures along her spine from an accident mountain biking. She and her husband fully expected at least a 6 week stay confined to a hospital bed as a result.

Natasha didn't wait long to see an Orthotist and be advised that by application of a CTLSO - a spinal brace that stabilises the fractures from her neck to her lower back- she would actually be up and walking in a day or two.

Practice regarding the treatment of spinal fractures and rehabilitation of spinal injury patients has changed from traditional bed rest to stabilising the spine via orthotic intervention and encouraging weight bearing and early discharge.

Evidence has shown that prolonged immobility is harmful with rapid reductions in muscle mass, bone mineral density and impairment in other body systems evident within the first week of bed rest. As well as being good for patients this approach saves the costs of a six-week hospital stay (versus the cost of supplying CTLSO and facilitating discharge) plus the cost of providing physiotherapy to rehab the patient after a period of immobility.

Discharge to Assess (D2A) – NHS Grampian
D2A is an intermediate care approach that aims to secure the early discharge of hospital in-patients who are clinically stable and do not require acute hospital care but may still require rehabilitation or care services provided with short-term support.

Intervention by D2A comprises up to 2 weeks of intensive assessment and rehabilitation in the patient's home from Occupational Therapy, Physiotherapy and an Advanced Nurse Practitioner with day-to-day support from Generic Support Workers working upon patient chosen goals.

The average length of treatment once discharged home with support from the D2A team was 11 days, making the cost per day of the D2A service per patient £169 compared with £570 for a Dr Grays Hospital bed day and £262 for a Community Hospital bed day. Readmission rates were also significantly reduced for individuals who have gone through D2A. Since launching, only 4% of D2A patients required assessment for care. 95% of D2A patients showed an increase in their functional performance in Activities of Daily Living (ADL).

Potential Development areas:

- Realisation of digital and assistive technologies to optimise patient outcomes and workforce capacity i.e. investment in access to appropriate digital therapeutic tools, home adaptions etc.
- Building on COVID learning to move from supplementary to independent prescribing for Dietitians could reduce delayed discharges from hospital (reduced need to wait for the doctor to alter prescription)
- Dietitians at the front door of hospitals to support identification of malnutrition could reduce length of hospital stay
- SLT as part of the acute front door MDT for immediate assessment and identification of appropriate support
- Podiatrists working at hospitals to accelerate the discharge of people with active foot disease with a smooth transfer to community services
- Smaller professions e.g. music therapy have had to redesign provision to ensure access to rehabilitation in the community as discharge planning does not always take account of on-going treatments. This has an impact on access in hospital as there is no increased capacity.

Reform of the NHS

Early intervention and prevention

Current case examples:

First contact physiotherapy (FCP) in primary care
Musculoskeletal conditions account for around one in four of all GP appointments. By replacing the GP referral system, considerable time is saved for GP practices. The input of specialist physiotherapy clinicians results in a dramatic reduction in unnecessary referrals, freeing up orthopaedic consultant time, and significantly reducing inappropriate referral for spinal imaging. For example, with only 1.5% of the 7000 patients assessed as requiring spinal imaging, at a total cost of £23,500 this compares favourably to another health board without this pathway service, where 2,200 patients are referred for imaging at a cost of £522,000.

Older Adults – Dramatherapy & Dementia Case Study
Referral - Enya and her partner were referred for 1-to-1 Dramatherapy in an NHS Older Adults Day Unit by a community mental health nurse. At this point Enya had little speech.

Dramatherapy Questionnaires were used to assess, and later evaluate, the extent of expressive meaning and dramatic involvement. Both Enya and her carer separately were introduced to a diversity of stress-relieving objects (props). Both people loved the animal glove puppets and the picture of a Lifetree populated with human figures. Later, these aided non-verbal communication at home.

Enya and her carer were each offered 14 weeks of weekly, 1-to-1 Dramatherapy. Projective play through pictures of different moods, miniature animal or human figures and reminiscence story books all helped Enya and her partner express their hopes and fears and process their experience of dementia. Added to this was embodiment play through movement and song.

Enya's quality of life increased by 75%. She found words easily to describe feeling like she was 'at the top of the tree', laughing. Her carer felt his quality of life had improved by 60%. Both sets of Jones questionnaire evaluation results demonstrated substantial clinical improvement and were shared with staff continuing to support the patient and carer. In clinical supervision, the dramatherapist reflected on qualitative improvements in Enya's mental health: Reduced aggression and elevated mood / Decreased confusion / Easier access to memory for word finding and sentence flow / Experience of being understood better through nonverbal and verbal communication / Expanded emotional self-expression and self-regulation

Happy birthday George
On his 92nd birthday George woke up disorientated, could not get out of bed and his wife Maggie noticed that his face looked droopy, and his speech was slurred. George was rushed into hospital as his symptoms indicated that he could be having a stroke.

As per care guidelines, George was seen quickly by the specialist stroke team as well as having a 'swallow screen' by a trained nurse within four hours of admission. George had some difficulty drinking water and was referred to the inpatient Speech and Language Therapists (SLTs) for assessment.

The SLT team prioritised George for assessment and headed to A&E where George's symptoms had started to resolve. The SLT carried out a case history with George and Maggie and a bedside swallow assessment which found that George was at his baseline for swallow function. He was able to enjoy a small amount of lemon drizzle cake in A&E before heading home for his own birthday cake and candles! People with ongoing symptoms are admitted to the integrated stroke unit where the multi-disciplinary stroke team continue to assess and manage their symptoms. For George, on his birthday, the collaboration of hospital staff and swift response from the inpatient SLT service contributed to George's timely discharge from A&E to get back home without the need for hospital admission.

Podiatry role in the identification of Atrial Fibrillation
In 2021, NHS Western Isles Technology Enabled Care (TEC) and Cardiac Nursing teams partnered with the Podiatry Department to enable on-the-spot digital single-lead ECG (Electrocardiogram) testing for patients suspected of an undiagnosed problem with their heart rhythm. The programme aimed to save lives, improve the patient diagnostic experience and make the best use of NHS services.
The Podiatry Team already carried out vascular assessments as part of their routine work. The introduction of the Kardia mobile device allowed the podiatrists to carry out additional checks during routine appointments. Before its introduction, ECG screenings were only available at GP practices or at specialist units.
Since NHS Western Isles podiatrists began using Kardia, over 80% of participants avoided the need for a GP ECG. This has helped significantly reduce the need for travel and additional appointments for many patients by ruling out Atrial Fibrillation (AF) at an earlier stage. The remaining patients have gone on to receive further cardiac investigations with some resulting in diagnoses of AF and heart failure. One particular case of early detection led to an urgent patient transfer by plane to the mainland for surgical assessment.

AF commonly displays no symptoms and affects an estimated 2.5% of the population, increasing the risk of stroke and cardiovascular issues. The estimated cost of providing care for a patient after a stroke is £22,500 for the first year and can have a devastating impact on a person's life. By incorporating this simple test into their routine vascular assessment, podiatrists can help reduce associated death and disability by contributing to the earlier detection of AF. This is just one of the many conditions that podiatrists are able to detect during appointments and help facilitate early intervention to save lives.

Potential Development areas:

- Dramatherapists being recognised as able to and leading on psychological therapies pathways would improve accessibility of services
- Funded orthoptic services as part of stroke care
- Diagnostic radiography – radiographer led services could enable increased community access e.g. mobile X-ray services, managing diagnostic hubs
- Embedding Speech and Language Therapists in the areas of highest need will reduce the long-term burden on the health system

Workforce

Current Case Examples:

Podiatry training eliminates foot ulcer referrals from local care home
NHS Fife's Podiatry Service identified that the number of referrals for foot ulcerations that were coming from one particular care home spiked in 2017 to eight per annum, and also that the majority of these ulcerations could have been prevented by care home staff.

In response to this, the Podiatry department delivered a series of 90-minute training sessions to care home staff. The training was based on CPR for Feet by the Scottish Diabetes Foot Action Group. The training covered how to check a person's feet to understand if action is required, how to protect a person's feet where necessary and how to quickly and easily refer to a Podiatry or multidisciplinary foot health team when necessary.

Thanks to the expert training from NHS Fife's local Podiatry team, which was received extremely positively from all care home staff, the number of foot ulcer referrals to Podiatry from that local care

home reduced from eight a year in 2017, to two in 2018 to zero in 2019. This meant that patient outcomes improved, whilst at the same time, the capacity of the local Podiatry team and therefore ability to concentrate on more complex caseloads was increased.

This example demonstrates the huge potential of podiatrists, AHPs, to improve patient outcomes through the sharing of knowledge and upskilling of other staff groups within Scotland's health and social care system. There is huge potential for this to be replicated throughout Scotland in order to multiply the gains which this successful model brings.

Podiatry musculoskeletal pathways deliver savings and earlier access to appropriate treatments
Within NHS Shetland, innovative podiatry pathways are saving money and ensuring that people are seen by the most appropriate clinician in the right place, at the right time.

NHS Shetland does not have an orthopaedic service on the islands, meaning anyone requiring this service has to travel to the mainland, which is costly and time consuming for the Health Board and the patient. As AHPs, Podiatrists have fully utilised their skills to develop local musculoskeletal (MSK) pathways, leading to improved outcomes for patients. All orthopaedic referrals from primary care in NHS Shetland are now triaged by MSK specialist Podiatrists. The podiatrist fully assesses the person before deciding which intervention would be most appropriate for their needs. The lead MSK Podiatrist also heads up a foot and ankle video conferencing service with the consultant orthopaedic surgeon at the Golden Jubilee Hospital in Glasgow. Patients attend a clinic in Shetland with the Podiatrist and Physiotherapist and are linked directly with the surgeon in Glasgow.

Should the patient be deemed inappropriate for surgical intervention, or would prefer not to have surgery, this allows the multidisciplinary team to discuss treatment options and the podiatrist to offer alternative treatments. Before these pathways were in place, numerous patients would have been unnecessarily referred onto the orthopaedic service or had to attend consultations on the mainland. Now, many are being given expert advice and access to appropriate treatments such as self-management programmes much earlier and closer to home, which is key to supporting the Scottish Government's 20:20 vision for healthcare.

This pathway is also increasing the capacity of the orthopaedic service by reducing their waiting times. Extended use of telephone and Near Me triage consultations, further reduces the need for local face to face contact. This pathway has huge applicability in healthcare across rural Scotland. By fully utilising the skills of Podiatrists within teams to develop similar models, costs will be reduced across health and social care, capacity will be increased, and ultimately patient outcomes will improve due to improving access to treatments quickly and easily.

Health and Education
Children and Young People – Speech and Language Therapists
Emma is a 10-year-old looked after child presenting with a high level of anxiety in school and in social situations. At school she would present as very verbally and physically aggressive and was often extremely tearful and anxious at home, frequently saying how much she disliked school. Whilst appearing very talkative, Emma struggled to talk about her feelings, explain her own thinking and use language to problem solve. She often did not pick up on more subtle communications from others in social situations and found making and maintain friendships very difficult. This led to her becoming frequently dysregulated and struggling to know how to manage her feelings.

Emma was referred to CAMHS. Her core worker queried a possible underlying neurodevelopment condition and wondered about her levels of understanding. Emma was subsequently referred to Speech

and Language Therapy for an assessment of her language, social communication and interaction skills. Following a block of appointments with a speech and language therapist, it was found that whilst Emma outwardly appeared chatty and able to hold a conversation, she found it very difficult to process and comprehend longer pieces of information, interpret key ideas, infer social information and predict. Her knowledge of vocabulary around emotions was also significantly reduced. She was therefore unable to verbalise her feelings as a way of regulating herself.

In order to support Emma, she was provided with a block of input around developing her knowledge of emotion words along with practising strategies to help Emma identify that she had not understood and to let people know this. In addition to this, the SLT developed a communication passport for Emma, which detailed Emma's communication strengths and areas that she found more difficult, along with strategies to help those working with Emma to support her understanding and participation. A meeting was held with the SLT and education staff for the SLT to go through the passport with those working with Emma and emphasising the importance of others adapting and modifying their own communication to support her.

Staff working with Emma now report they feel much more able to communicate with her in an effective way. Emma's levels of anxiety and verbal/physical aggression have greatly reduced. She is more able to regulate her emotions, with key transactional supports from those around her and has learned phrases to use to indicate when she had not understood and ask for help. She no longer requires support from SLT directly. Very few difficulties have been reported since, and she has continued with mainstream education for three years.

Further examples can be found in the AHPFS compendium.